Fall 12-18-2015

A Population Health Approach for Community Health Improvement

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Acknowledgments

It is with the deepest of gratitude that I thank the extraordinary faculty and leadership of the University of San Francisco's Doctorate of Nursing Practice program: Dean Judith Karshmer, Dr. Marjorie Barter, Dr. Mary Bitner, Dr. Brian Budds, Dr. Judith Lampton, Dr. Juli Maxworthy, Dr. Amy Nichols, and Dr. KT Waxman. You have inspired me, deepened my commitment to nursing, elevated my professionalism in practice and ignited my passion for life-long learning.

Special thanks to my magnificent committee. Dr. Barter, I am so blessed to have you as my chair, advisor and mentor. You are the quintessential role model, and I am a better student, colleague and person for having you in my life. Dr. Maxworthy and Dr. Godfrey you brilliantly helped to refine my thoughts and perspectives. I am forever indebted to each of you for your generosity of time, knowledge and encouragement.

Thank you to my friends and colleagues who have walked along-side me on this journey, especially my leader, Joel Gilbertson, who truly eased my way. Your incredibly support made this experience a joy. I will be forever grateful to my very special classmates: Richard Billingsley, Diane Bartos, Elizabeth Bigby and Veronica Bargas for the hours and hours we spent on the phone, in restaurants, and late at night learning, debating, crying and laughing. You will always be Group 1 in my heart.

Finally, I dedicate this project to my precious family. Jay, my love for you is timeless. Austin and Spencer, you are God's gift to me and the greatest joys in my life. Carol, Lauren and Ryan I love you deeply and unconditionally. And sweet Kennedy you are the rising star that makes my heart sing.

Abstract

Providence Health & Services (Providence), a not-for-profit Catholic health care system serving five western states, established an organizational vision of *Creating healthier communities, together* (Providence Health & Services, 2014). This vision served as the catalyst for the alignment of divisional initiatives to positively impact community health status. To effectively achieve its vision, the organization committed to the incorporation of population health principles in the development of an infrastructure to expand the reach and impact of community investments, along with the establishment of effective processes for inter-divisional collaboration and compliance with community benefit mandates. Thus, in 2015, Providence established a community investment governance structure and strategic framework, standardized community assessments and health improvement planning, centralized data collection and storage, and, standardized reporting guidelines. As a result, functions that had been decentralized across 34 hospitals were reorganized in a manner that brought local efficiencies with minimal organizational disruption. Furthermore, the governance structure served as a venue for the transformation of community benefit functions that have been reactive to the needs of the community into one that is proactive in working in partnership with community leaders to increase the community's capacity for health.

Keywords: community benefit, community health, community investment, population, population health, population health framework, population health model

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Other Information

Background Knowledge

Overview and description of the healthcare challenge.

Over a century ago, New York City Health Commissioner Herman Briggs declared that "Public health is purchasable…within natural limitations, a community can determine its own death rate" (Winslow, 1929, p. 120). Those very words resonate today with researchers, practitioners, policymakers, public health, and delivery system leaders. Despite an expressed goal of creating healthy communities, the United States (U.S.) performs poorly in terms of life expectancy and significant health outcomes, as compared to its global peers. This poor performance is a direct reflection on priorities. As a nation, the U.S. invests lavishly on clinical care, yet frugally on population-based services known to have a more profound impact on health status than medical services (Institute of Medicine [IOM], 2012).

During the early 1900s, the U.S. capitalized on the development of a public health system to address the unmet health needs of individuals; at same time, Canada focused on the creation of population health models and structures to care for its citizens (Friedman & Starfield, 2003). While the terms *public health* and *population health* are often used interchangeably, they represent concepts that have fundamental differences in the way healthcare is delivered. Friedman & Starfield suggested that public health programs are designed to address the identified health needs of individuals; whereas, population health programs focus on improving the health status of a population or subpopulation.

Not all scholars defined the role of population health and public health in the same way as Friedman and Starfield. Gostin and Powers (2006) exemplify another perspective. They described the role of public health in much broader terms, including accountability for assessing and intervening on health threats, public education, mobilizing community partnerships, and

shaping and enforcing state health laws. The authors acknowledged that the execution of public health functions is dependent on public support and funding which are often insufficient. The lack of a clear and consistent definition for public and population health contributes to confusion of roles and accountabilities across all sectors committed to health improvement.

In the current environment of healthcare reform, health systems have an increased accountability for the health status of the community in which they offer services. This has served as a catalyst for healthcare organizations to pursue innovative care delivery models that direct services at the population level. These models are dependent on new organizational and professional competencies. Factors related to the community's social environment, socioeconomic resources, natural and built environment, biology, early childhood development, and political context all become essential knowledge for program planning and implementation. The U.S. health system is well poised to incorporate these new perspectives into healthcare decision making. Public and proprietary sources of big data are robust and readily available; a simple Google search yields over 995,000 sources of demographic data in less than 30 seconds. The daunting task is to organize the relevant data into information that informs healthcare leaders how to transform existing systems and services to address the health needs of groups of individuals. Canada and Britain have been on this journey for over a century and offer care models that may serve as a foundation for the emerging U.S. systems of care. One in particular, the population health framework, offers a promising model to achieve emerging health reform expectations.

The setting.

Incorporated in 1856 by a Catholic community of women religious, the Sisters of Providence, Providence Health & Services (Providence) is a not-for-profit healthcare

organization committed to working in collaboration with others to improve the health of the community. Originally founded as a Catholic organization, Providence now sponsors both religious and secular entities across five western states: Alaska, California, Montana, Oregon, and Washington (Appendix A, Providence Health & Services Locations). During its 160 years of formation, Providence has evolved into an expansive system of hospitals, physician clinics, home care, palliative and hospice services, long-term care facilities, supportive housing, health insurance, and academic institutions.

Between the years 2011 and 2014, Providence experienced an unprecedented rate of growth. The 27 hospitals, 53,000 employees, and $5.4 billion in net assets reported by Providence in 2011, expanded to 34 hospitals, 74,000 employees, and $11 billion in net assets by 2014. The growth will continue into 2016, with a projected increase in services and revenue by 30%.

Influenced by the Catholic value of subsidiarity, until 2013, Providence had been structured as a holding company characterized by a small corporate office and vast decentralized programs and services. At that time, Providence restructured its operations into an operating company and centralized core administrative functions, including human resources, finance, information services, marketing and communication, and government affairs. The strategic intent of the new structure was to optimize operational efficiencies to position the organization for ongoing financial stability and to create an environment that promoted collaboration across clinical and administrative services to be more responsive to community needs. The early results were encouraging. The new structure allowed for heightened organizational nimbleness, enhanced decision making, and increased speed for replicating best practices. However, there were unintended cultural implications.

Transitioning to the new structure disrupted well-established local relationships and work processes, as well as shifted the locus of authority and decision making away from decentralized divisions of the organization.

Emerging perception of community health initiatives.

In 2014, Providence's executive leadership team launched a strategic plan with the core strategy of *Creating Healthier Communities, Together*. Providence is not alone in its commitment to creating healthier communities. As the cost of healthcare continues to escalate, the U.S. Congress has been investigating various approaches to promote health improvement programs. Not-for-profit, tax-exempt hospitals have been under scrutiny in recent years to demonstrate how they have offset the value of their tax-free status by investing in community health improvement initiatives. Typically tracked and reported as community benefit, tax-exempt hospitals are required to offer programs and services in the community that equal or exceed tax payments for which they would have been accountable if deemed a taxable entity. Beginning in 2008, tax-exempt hospitals commenced mandated annual reporting of all community benefit activities to the IRS. With the passage of the 2010 Patient Protection and Affordable Care Act (ACA), non-profit 501(c)(3), acute care hospitals were directed to conduct a Community Health Needs Assessment (CHNA) and Implementation Strategy at least once every three years and report on financial assistance and billing and collection practices (Internal Revenue Service [IRS], 2014). Each of Providence's 34 acute care facilities is required to comply or risk a loss of their tax status.

Organizational knowledge and expertise.

Providence's acute care facilities have a well-established process for conducting community needs assessments; in fact, many have done so since the 1990s. Each facility

employs an individual who is accountable for community benefit activities and compliance. Eleven individuals serve in this role, with their scope of program oversight ranging from one to 10 hospitals. Nearly 50% of the individuals are dedicated to the role full-time, and others are accountable for a breadth of additional duties. One individual has a clinical background, three are chaplains, and the remaining individuals have planning and program management experience. Each of the community benefit leaders works independently and reports to the local management team. Until recently, the community benefit leaders did not have a formal venue to network with their peers across facilities or communities.

Impetus for addressing the healthcare challenge in 2014.

Providence's strategic focus on creating healthier communities served as the catalyst for the alignment of initiatives across all divisions to positively impact community health status. To advance the strategy, the organization committed to the development of an infrastructure to expand the reach and impact of current community investments, establish effective processes for collaborating on health improvement initiatives, and ensure compliance with community benefit mandates.

Local Problem

Implications of the healthcare challenge for Providence.

Striving to be a national leader in creating healthier communities, Providence invested significant financial resources in community health initiatives, yet had not seen a proportionate improvement in community health status. Historically, Providence executed its community health initiatives in a manner similar to a public health model. That is, Providence's experience and expertise was in the ability to identify health needs of select individuals and design and implement essential programs and services. The individuals who received care may experience

improvements in their health status; however, the community as a whole did not become healthier. In fact, the combined average ranking by state for Providence markets decreased from 23rd to 25th between 2010 and 2013 (Providence, 2014, 2015; The Commonwealth Fund, 2014).

Additionally, community benefit functions remained decentralized throughout Providence. Therefore, each community benefit leader had the authority to execute an assessment and health improvement plan for their community. As a result, the findings were rarely comparable due to inconsistencies in data collection methodologies, sophistication of tools, and resources for data analysis, limiting the identification of organization-wide trends and opportunities for collaboration on initiatives across communities. To effect change on a community-wide level, the selection of health improvement initiatives, guided by an epidemiologic methodology and implemented in collaboration with community partners, was required.

History of performance and impetus for change.

Providence's traditional approaches to quality improvement and healthcare delivery are no longer effective in achieving community health and wellness goals. Between 2010 and 2014, Providence invested nearly $4 billion in community benefit and programs in five western states; however, significant improvements in healthcare access, quality, costs, and outcomes have not been achieved in relation to the other 46 states. Given Providence's significant community investment without the achievement of proportionate gains in health status warranted a new approach to community health improvement. Providence was prepared to reorganize its structures and processes to enhance its effectiveness in impacting community health status and ensure regulatory compliance.

Intended Improvement/Purpose of Change

Aim Statement.

In order to optimize its community health investments, Providence will transform the systems and structures designed to improve the health of the communities in which it offers programs and services. To achieve this goal, Providence will establish a governance process, develop a community health investment framework, determine organization-wide priorities for advancing a population health approach, standardize existing tools, and establish common success measures by June 2015.

Change impetus.

Given Providence's significant community investment warranted a new approach to community health improvement. Providence was prepared to reorganize its structures and processes to enhance its effectiveness in impacting community health status and ensure regulatory compliance. The project was aligned with the organization's core strategic priority, and internal stakeholders expressed a desire to be engaged in the project and collaborate across the organization.

Question.

The project was designed to answer the following the question: How should Providence organize its community investment systems and structures to achieve the optimal community health improvement impact?

Review of the Evidence

The U.S. health system's focus on individual health and clinical practice has resulted in a void of epidemiologic research and studies on population health models and frameworks. (Friedman & Starfield, 2003). Therefore, a literature review was conducted to explore related

care frameworks: the population health framework for the Canadian and British health systems and a review of models in the U.S. and Canadian public health nursing field. These bodies of knowledge offer a rich array of approaches for caring for populations.

As depicted in Appendix L, Evidence Table, fourteen articles were reviewed and evaluated for strength and quality of the evidence, sampling methodology and study findings using the John's Hopkins non-research evidence rating guidelines (Newhouse et al, 2007). A rating scale from one (1) to five (5) was used to depict the strength of the evidence with 1 denoting the strongest. In addition, the quality of the evidence was scored as high (A), good (B) or low (C). Of the twelve articles focused on population health models and approaches in Canada and Europe, ten of the articles were expert opinions rated as 5A. This rating indicates that the articles were rated as level 5 in terms of research design, yet were of high quality in presentation of the subject matter and findings. Of the remaining two articles on this topic, one was a qualitative study and the second was a meta-analysis. Both were rated as 3B to reflect the limitations in sample size and applicability of findings.

The final two articles were described the impact of public and population health in nursing. The first was a system review of existing care models and was rated as 4B in recognition of insufficient evidence for the authors to come to a definitive conclusion. The second was a literature review that was rated as 5A for its comprehensive presentation of the information.

Defining population health.

There is little, if any, agreement on a common definition of public health and population health; however, there remains abundant concurrence as to the differences in public and population health models. Friedman and Starfield (2003) describe the difference between the

concepts as population health is a focus on the improvements in the health of the population and sub-groups; whereas, public health is concerned with improvements in the health of individuals. A principle of population health is the acknowledgement of multiple determinants of health, including medical care; public health interventions; the social environment, such as income, education, employment, social support, and culture; the physical environment, for example, urban or rural setting, air, and water quality; personal genetics; and individual behavior (Kindig & Stoddart, 2003). In contrast, public health services have been traditionally delivered alongside of, as opposed to integrated with, other resources. Thus, population health models provide a framework that enriches public health practice by providing structure for program design and implementation (Friedman & Starfield, 2003).

In the field of population health, divergent opinions on its definition and how it differs from public health remain. Experts continue to debate whether the concepts are the same or different. Stoto (2013) argued that there is a difference and that it matters. According to Stoto, the essential differentiator is that population health is not limited to governmental health department engagement or funding. The IOM declared population health differs from public health by the way that care is delivered. In the report, *For the Public's Health: Investing in a Healthier Future,* the IOM highlighted that population health required partnerships that include and go beyond traditional public health agencies and health systems (IOM, 2012). The report indicated shared data, defined accountability, and outcomes were distinguishing elements of a population health approach. The functions outlined in the IOM report may be beyond the public health system's current scope of authority; however, it may be its future as the U.S. health system continues to evolve. According to Frank (1995), the "shift in thinking entailed in population health should be a small one for public health workers…it is not so much a shift as a

return to our historical roots encompassing all the primary determinants of health in human populations" (p. 163).

Literature on Canadian population health models.

A focus on care for populations has been a hallmark of the Canadian health system throughout the 20th century. In the 1970s, a commitment toward new approaches in health improvement resulted in several divergent movements. The government focused on new models of care to improve health, while research scientists gave attention to underlying causes of disease and health.

During the 1970s, Thomas McKeown, a British professor of social medicine, influenced two of the major theories that when converged became known as population health. Health promotion was the first of these concepts and was introduced in the Lalonde report of 1974 (as cited in Glouberman & Millar, 2003). The second was the launch of research focusing on inequalities in health. Both of these movements highly influenced how data were gathered and disseminated throughout Canada in the 1970s, 1980s, and 1990s, yet had little influence on health policy (Glouberman & Millar, 2003).

By the late 1980s, Canadian health promotion programs focused on improving health in schools, workplaces, and communities. When evaluating the impact of the programs, the emphasis was on process, not outcomes. In the absence of measureable outcomes, the programs came under negative scrutiny in the early 1990s when escalating healthcare expenditures led the government to cut spending. As in the U.S., the cost savings generated by the programs were outpaced by new therapeutics and technology.

Another flaw in the programs was that the health promotion messages were adopted more readily by advantaged populations, yet they did not demonstrate an improvement in health status.

Studies found after programs on fitness were introduced, individuals exercised more, but they also watched television more (Glouberman & Millar, 2003). Likewise, individuals improved their diets, but they ate more. The result was a worsening of both health inequalities and community health status. To understand the overall impact of the federal health promotion programs, the Canadian government engaged Price Waterhouse, who validated that the programs alone were not impactful in increasing community health status and concluded that health as a product "does not readily lend itself to being actioned" (Glouberman & Millar, 2003, p. 3).

While the government was seeking ways to optimize national health promotion programs, Canadian health researchers began to correlate the trends in health status with socioeconomic variables. Two of Canada's premier researchers, Evans and Stoddart (2003), concluded that social and economic factors are far more impactful on health than individual behaviors. This insight shifted the focus toward addressing the root causes of health inequalities (Glouberman & Miller, 2003).

After studying the findings of the health promotion programs, McKeown noted that health promotion efforts must be supported by scientific research. In addition, the execution of the programs required public, private, and governmental collaboration. This interconnectedness was referred to by McKeown as a population health approach to health improvement (as cited in Glouberman & Millar, 2003, McKeown, 1979).

Evans and Stoddart (2003) developed a conceptual framework to establish a relationship between determinants of health and the health of a population. The intent was to create an evidence-based framework that highlighted how the interaction of factors impact health outcomes. Presented in Appendix B: Population Health Models, their model depicted the relationship between nine determinants: the social environment, the physical environment,

genetic endowment, individual response, health and function, disease, healthcare, well-being, and prosperity (Evans & Stoddart, 2003).

In 2003, Evans and Stoddart offered a critique of their framework, since it was published in 1991. They acknowledge that the simplicity of the framework was not reflective of the complexity and interconnectedness of determinants of health. Additionally, they pointed out that the presentation of the factors did not depict the level of impact each factor had on health status. The model suggested all factors were equal, and the authors acknowledged that this was an oversight. In particular, they noted that the model does not fully illustrate the importance of income in predicting an individual's health status (Evans & Stoddart, 2003).

Evans and Stoddart's critique of their framework was published at the same time that Coburn et al. (2003) submitted their reflections on the model. They praised the model for demonstrating the linkage between economies and societies and health, yet they also acknowledged several limitations. The first limitation is that the model analyzed determinants of health at the macro level and excluded micro level factors, thus did not address the way that people, individually and collectively, acted to improve health. Secondly, Coburn et al. felt the model simplified the inherent complexity and interrelationship of the factors influencing health. Third, the model suggested that socioeconomic conditions impact health status, but it does not address the relationship between discrepancies in socioeconomic factors and the role of policymakers (Coburn et al., 2003).

Coburn et al. (2003) stressed the importance of balancing a research-driven analysis of the population with an understanding of the people and their interconnections in the population. The authors emphasized the value of perceiving how individuals and groups viewed their world and engaging community stakeholders in creating healthy communities and environments.

In 2003, Friedman and Starfield published a review of population health models as depicted by recognized leaders in the industry, including Szreter, Evans and Stoddart, Kindig and Stoddart, Kickbusch, Glouberman and Millar, and Coburn. Each of the models differed in significant ways. At the core were variances in the definitions of population health and differing categories of factors affecting population health and how those factors impact health outcomes. Friedman and Starfield concluded that the optimal model would incorporate a broad array of health factors that are inclusive of both illness and wellness status and include point-in-time outcomes along with longitudinal measures (Friedman & Starfield, 2003).

Szreter (2003) offered a historical perspective on the emergence of population health trends since the 1500s. Given that the first clear reference to a formal population health approach is a 20th century construct, Szreter thematically connected the growth in the economy to observed changes in the health of the population over several centuries. While particular health concerns varied by time period and world location, significant improvements in the health of a population were typically linked with improvements in the economy; whereas, the inverse was not observed. That is, the growth of the economy resulted in population health improvement only when the state or federal government intervened and reallocated a portion of the new wealth toward programs and services that directly influence determinants of health. Szreter articulated the importance of ethical principles, effective strategies, and policies to address the health challenges of the 21st century. In a global environment, a population health approach was deemed to be essential for society to understand the epidemiological early warning signs that are only manifest at the population level (Szreter, 2003).

Kindig and Stoddart (2003) depicted population health as three forces that advance the health of a population. The first was that population health is strictly influenced by independent

variables, that is, the social and economic determinants of health. The second was that population health should be concerned with dependent variables, such as measurable health outcomes for a defined population. The third, and optimal, approach was the integration of the determinants of health and the measurement of health outcomes. Kindig and Stoddart's framework highlighted the interconnectedness of health outcomes and distribution in a population (dependent variables), patterns of health determinants over the life course (independent variables), and policies and interventions at the individual and social levels.

In 2006, Dunn discussed the connection of social epidemiology and population health. Recognizing that the methodology used in the natural sciences may not adequately address the complexity of a population health construct, Dunn suggested that the traditional frameworks cited in the population health literature be supplemented with those supported by the social sciences. Dunn did not offer a comprehensive framework or definition for population health; rather, he cautioned that the existing models may not present the complexity that is inherent in a broad definition of population health.

Around the same time, Kindig (2007) demonstrated a refinement in his perceptions of population health frameworks in his manuscript, *Understanding Population Health Terminology*. Utilizing Evans, Barer, and Marmour's framework for population health, Kindig discussed the importance of a common lexicon when referring to population health models. Terms of particular importance were population and health, population health outcomes, determinants of health outcomes, and policies and interventions. Kindig suggested that a deeper understanding of the terms is essential to fully appreciate the relationships among and between the framework components. In addition to his focus on terminology, Kindig noted that given the longitudinal nature of population health, the measurement of health outcomes should include traditional short

and long term outcomes, as well as intermediate term outcomes to evaluate the causal effect(s) on health and guide policy.

In 2014, the Public Health Agency of Canada (PHAC) published a framework for population health that focuses of eight key elements: focus on the health of populations, address the determinants of health and their interactions, base decisions on evidence, increase upstream investments, apply multiple interventions and strategies, collaborate across sectors and levels, employ mechanisms for public involvement, and demonstrate accountability for health outcomes. To advance the assimilation of these principles nationally, the PHAC developed a user-friendly resource guide that described each component of the framework, delineated the purpose for the element along with key resources, and outlined specific action steps to achieve specified health improvement goals, thereby disseminating the tools to accelerate health improvement (PHAC, 2014).

Seeking to understand how Canadian health leaders were defining and applying population health concepts, Cohen et al. (2014) conducted a qualitative study of 21 leaders. The goal was to capture their perspectives on the way they conceptualized and operationalized population health principles into their planning and decision making. Among the participants, there was a convergence of opinions on six core elements of a population health definition: focusing on health and wellness prevention rather than illness; taking a population rather than individual orientation; understanding needs and solutions through community outreach; addressing equity, health disparities, and health in vulnerable groups; addressing the social multiple determinants of health; and embracing inter-sectional action and partnerships. While there was strong alignment of the components of a population health approach, several divergent perspectives were noted in the way that the approach was executed. The major themes were

shifting from service-based to person-centric models of care; a philosophical approach, an ideology; a long-term approach requiring long planning horizons; and targeted versus enterprise-wide implementation models. Cohen stated that the difference in the way population health was operationalized was directly correlated to the specific population they are serving and the availability of human and financial resources for interventions.

Cohen et al. (2014) conducted an assessment that brought to light the importance of vision and leadership for advancing population health strategies into mainstream healthcare systems. The thought leaders featured in the study were selected for their knowledge and effectiveness in furthering a population health agenda; however, they identified that there are multiple political and financial issues that create barriers to gains in momentum for this work.

Literature on European population health models.

In 1986, the World Health Organization (WHO) sponsored an international conference on health promotion in Ottawa, Canada (in Kickbush, 2003). Based on the perspectives adopted at the conference, the Ottawa Charter for Health Promotion was developed and drove the public health debate, health policy formulation, and health promotion practices in many European countries. Central to the Ottawa Charter was a redefinition and repositioning of institutions, communities, and stakeholders at the "health" end of the disease – health continuum. By migrating away from an individualistic focus on lifestyles toward social environments and policy, the orientation of health promotions began to shift from the management of individual risk factors to determinants of health.

The Ottawa Charter echoed WHO's European *Health for All* goal of health policy as the provision of a socially and economically productive life for all people. The intent was for governments to be accountable for the health of their populations, not just for the health services

they fund or provide. The charter suggested that health is a resource for living and that there must be a commitment to social reform and equity that yields a greater capacity building for health. The European approach of understanding lifestyles as collective behaviors in a population differed from that of the U.S. focus on individual behavior modification. As a result, the U.S. health improvement practices followed a reduction in disease model; whereas, the WHO European countries moved toward a social model of health approach.

The divergent approaches in health policy between the U.S. and the European countries paralleled the expanding differences in social reform and cultural norms. The collective lifestyle growth in 1970s Europe provided fertile ground for the growth of a social health model in the 1980s. In contrast, the individualistic culture in the U.S. generated health policy that was focused on individual values. The European adoption of a social health approach in the 1980s matured into the WHO Healthy Cities project, where local leaders in public and private healthcare, business, faith communities, and city government work in partnership to optimize the community's health. The European countries acknowledged that healthy communities and work places played a central role to wealth creation and investments in human and social capital and are essential to stay competitive on a global scale. Yet, even with the reorientation in health strategy, the focus of European health policy remains on medical care expenditures rather than determinants of health (Kickbusch, 2003).

Literature on U.S. population health models.

Stoto (2013) explored the potential for a population health approach to achieve the U.S. health reform goals. Stoto's intent was to advance the evidence base for effective population health policy and practice. The passage of the 2010 Patient Protection and Affordable Care Act (ACA) effectively directed the attention of U.S. healthcare leaders and policy makers toward

population health by introducing insurance coverage expansion, quality of care initiatives, prevention and health promotion efforts, and provisions aimed at promoting community and population-based activities. The ACA also added an IRS requirement for the conduction of Community Health Needs Assessments (CHNA) every three years in an attempt to leverage the strengths and resources of the private and public healthcare systems.

Stoto (2013) cautioned that the ACA legislation is not enough to embed population health concepts into the U.S. health delivery system. Funding new models of care requires a growth in the economy with a portion allocated toward programs and services that directly influence determinants of health. Stoto suggested that research is needed to generate evidence that demonstrates which upstream interventions have a positive influence on health outcomes and are effective for all populations or sub-populations. This is essential given the wide variations in the U.S. geography and cultures. In addition, new methodologies for data analysis must be designed that are capable of the rigor required to understand outcomes at a population level. The individual level epidemiological studies and patient-level randomized clinical trials will need to give way to quasi-experiments, observational approaches, and mixed-methods approaches such as realist evaluation.

Literature on Canadian and U.S. public health nursing models.

Nursing theory is steeped in a holistic approach to assist patients and families to improve and optimize health. This expanded view of the determinants of health calls nurses to look beyond their immediate surroundings toward broader drivers of health and disease. Given that the promotion of health and healing is central to nursing practice, an understanding of the multi-level determinants of health is an imperative (MacDonald, Newburn-Cook, Allen, & Reutter, 2013).

MacDonald, Newburn-Cook, Allen, and Reutter (2013) described how the population health framework, as defined by Canada's Federal/Provincial/Territorial Advisory Committee on Population Health, has relevance for nursing research in the promotion of health. The authors addressed the determinants of health foundational to the framework and how the interconnectedness of the elements contributed to health outcomes of individuals and populations. Their framework focused on seven determinants of health: social and economic environments, physical environments, early childhood development, health services, personal health practices, individual capacity and coping skills, and biology and genetics.

MacDonald et al. (2013) stressed the importance of distinguishing between social determinants of health (SDH) and a population health framework. The SDH include elements related to the social and political environment, to the physical environment, and to early child development. In addition to the SDH, a population health framework also takes into account personal health behaviors, individual capacity and coping skills, genetics, and biology. Therefore, a population health framework is a more inclusive approach to healthcare delivery and was concerned with multiple factors and the interaction between them.

MacDonald et al. (2013) asserted the role of nursing was to support individuals, families, and the community to enhance, maintain, and recover health; thus, attention to the elements of a population health framework was essential. Nursing research that focuses on the individual experience is unlikely to allow for the insight gained from a holistic view that a population health perspective may provide. MacDonald et al. suggested there was a need to expand the existing research to explore the multi-level influences of health and how they intersect and influence one another. By deepening nursing's understanding of the ways that social and physical factors

interact with individual-level factors, nurses can be more effective in designing interventions that improve health outcomes.

Similar to the Canadian nursing literature, little research has focused on population health by U.S. researchers. Striving to identify a relevant theory-based approach to guide population-focused U.S. public health nursing practice, Bigbee and Issel (2012) evaluated 12 conceptual models based on four qualities: promotion of nursing as a discipline, public health practice and competencies, application to public health nursing practice, and documentation of application / empirical testing. The authors concluded that many of the models demonstrated several of the desired elements to advance public health nursing practice; yet, they were not able to identify one model that fulfilled all expectations. Bigbee and Issel (2012) concluded that nursing must refine its existing model or explore the integration of several models in order to optimize the role of public health nursing in the promotion of population health.

Conceptual and Theoretical Frameworks

Providence can look to conceptual models in population health, nursing, and change management to guide the development of systems and structures to optimize its community health investments.

Conceptual framework in population health.

A principle of population health is the acknowledgement of multiple determinants of health, including medical care; public health interventions; the social environment, such as income, education, employment, social support, and culture; the physical environment, for example, urban or rural setting, air quality, and water quality; personal genetics; and individual behavior (Kindig & Stoddart, 2003). In addition to the inclusion of a broad array of factors in determining interventions, a population health approach stresses the importance of the

collaboration of public and private organizations in addressing community health concerns. Thus, population health models provide a framework that enriches public health practice by providing structure for program design, implementation, and evaluation (Friedman & Starfield, 2003).

Theoretical framework in nursing.

In her Systems Model, nursing theorist Betty Neuman offered a holistic perspective to understanding health (Gonzalo, 2011). According to Neuman (2007), an individual's health status is influenced by an interconnected system of physiological, psychological, sociocultural, developmental, and spiritual factors. These components offer direction for goal setting and the development of interventions at the individual or population level. Designed to be a health systems model appropriate for all health professionals, the concepts are relevant for planning the care of one individual, or an entire system, and can be applied to curriculum planning, policy development, and research and evaluation (Gonzalo, 2011; Neuman & Reed, 2007).

A distinguishing feature of Neuman's model is the inclusion of interdisciplinary collaboration and client and/or community partnership with the healthcare system (Neuman & Reed, 2007). Neuman noted that the model was designed to be responsive to the evolving priorities by offering a framework that can organize the expanding pool of data and knowledge to guide the coordination of services across venues and disciplines. Neuman emphasized the model's particular importance to urban leaders for creating healthier communities. (Neuman & Reed, 2007; Neuman & Fawcett, 2012).

In 2015, Fawcett and Ellenbecker introduced a conceptual model of nursing and population health. The model focused on four interconnected social determinants of health: upstream factors, population factors, health system factors, and nursing activities. The upstream

factors included the socioeconomic and physical environment. Population factors referred to genetic, behavioral, physiologic, resilience and health status elements. The healthcare system factors were the providers, organizations, payers, and policies. Each of these factors was operationalized through population-based nursing processes and culturally sensitive practices. Fawcett and Ellenbecker's (2015) model highlighted nursing's contribution in advancing population health.

Change management framework.

In 1989, under the leadership of Jack Welch, Chairman of the Board and Chief Executive Officer, General Electric Corporation (GE) launched a team-based problem-solving program that was modeled after the Japanese quality circles model (GE, 2003). While the program was successful in resolving issues, Welch observed that there was a slow adoption rate throughout the organization. Envisioning a growing importance for organizational agility to adapt to change, Welch commissioned a team to develop a change management tool kit that managers could easily put into practice. The result was the Change Acceleration Process, commonly referred to as CAP (GE, 2003).

Foundational to CAP is the Change Effectiveness Equation (GE, 2003). This principle emerged from insight that a high-quality technical strategy solution alone is insufficient to guarantee success of a project. Rather, when there was a lack of attention to the cultural factors, projects were often derailed – not the technical strategy. From this observation came the creation of the Change Effectiveness Equation, Q x A = E; where, the effectiveness (E) of any initiative is equal to the product of the quality (Q) of the technical strategy and the acceptance (A) of that strategy. In short, the people and cultural elements of the equation are as important as the technical factors. It is noteworthy that the elements of the equation have a multiplicative

relationship; if there is a zero for the acceptance factor, the total effectiveness of the initiative will be zero, regardless of the strength of the technical strategy (GE, 2003; Von Der Linn, 2009).

The Change Acceleration Process model (Appendix C) depicts seven steps to optimize the success of organizational change:

1. Leading change – it is imperative that the project has authentic, committed leadership throughout all phases of the project.
2. Creating a shared need – the need for the change must outweigh the resistances and the inertia of the organization to maintain the status quo.
3. Shaping a vision – leaders must articulate a clear and compelling vision of the state of the organization after the change in individual behavioral terms, not business results.
4. Mobilizing commitment – begin with early adopters to pilot the project and begin to execute the strategy to build momentum.
5. Making change last – leverage early wins and transfer knowledge gained in pilots, integrate the project as appropriate with other organizational initiatives, and assess what is helping or hindering the project.
6. Monitoring progress – establish a baseline and metrics for the desired change, measure against the metrics routinely, celebrate successes, and determine consequences for lack of progress.
7. Changing systems and structures – adapt existing structures, such as policies, information systems, and organizational design, to support the future state of the organization in a manner that reinforces the new behaviors.

Failure to address any component of the model can result in increased resistance, lack of support or resources, extended time to institutionalize the change, or project failure (GE, 2003; Von Der Linn, 2009).

In the mid-1990s, Providence embarked on an organization-wide strategy to incorporate GE's project management techniques into its standard business practices. Providence engaged GE consultants to guide the establishment of an Operational Excellence division. This division has been accountable for the development of project management competencies throughout the organization. Since the adoption of the GE approach, the Providence leadership team has completed training on the change management process, and hundreds of project managers have been certified on the methodology. Given the organization-wide familiarity of the CAP model, this change management methodology was utilized to plan and execute the project.

Integration of conceptual and theoretical frameworks.

The essential elements of these models provide a roadmap for Providence to improve its effectiveness in impacting community health. Neuman's core concepts of the interconnectedness of health factors offered a structure for addressing health concerns at the macro-system or population level. The various population health models reinforce Neuman's model and expand it by introducing the importance of aligning community health strategies and policy-making priorities. The GE CAP model offers a roadmap for introducing the project to internal stakeholders and guiding them through a process that embraced engagement, optimized buy-in, and hardwired desired change.

Methods

Ethical Issues

Ethical insights and implications for the project.

Providence's 2013 organizational restructuring resulted in changes in authority and decision making for leaders throughout the organization. In some cases, levels of authority were redistributed to new leaders; for others, their levels of authority were expanded. This resulted in organizational disruption, as well-established roles, relationships, and workflows were disordered. At the core of the disruption was an emerging cultural tension resulting from the centralization of functions and loss of local decision-making. Healthcare ethics literature suggested the negative human response resulted from a perceived in-balance of power as described by the moral principles of autonomy and paternalism.

According to Christman (2015), autonomy is a concept that refers to the capacity to be one's own person and to live one's life according to motives that are one's own and not the product of external forces. In its purest definition, autonomy is at the opposite end of the continuum from paternalism. Paternalism describes actions that are taken for the good of another, without that person's consent. While its end is to be benevolent, its means can be coercive (Suber, 1999). To extrapolate the concepts of autonomy and paternalism to an organizational perspective, autonomy refers to an individual's sense of control and decision-making authority over their defined scope of responsibility. In contrast, paternalism refers to external directives that influence the way an individual executes their work. In the case of organizational structures, entities that delegate decision making downward offer higher levels of individual autonomy; whereas, organizations that centralize decision making are more likely to have a greater number of paternalistic workflows. Given the intrinsic value of an autonomous

state, individuals naturally resist the transition from decentralized to centralized organizational structures.

By 2013, Providence had been fast-tracking its restructuring efforts and found that each time a service or function was centralized, there were dramatic impacts to the organizational culture and employee perception of roles. As the locus of authority and decision making shifted away from decentralized divisions toward a centralized service, the power balance and relationships between the two components of the organization changed. This was a vulnerable time for Providence. Experts in organizational development caution that when leaders and staff of local divisions are being held accountable for decisions made elsewhere without their input or buy-in, resistance often develops that slows the transformation at best and may halt improvements in care at the worst (McLaughlin, 2013).

According to Scott, Mannion, Davis, and Marshall (2003), when organizations increase their focus on efficiency and performance metrics and at the same time decrease authority in local divisions, the organization becomes at risk for negative performance behaviors. *Tunnel vision* may result from directing the majority of resources on a critical few initiatives and under resourcing other important efforts. With heightened visibility and attention on performance metrics, data may be misrepresented or falsified to achieve targets. Complacency for organization-wide quality and performance improvements can occur due to generalized staff apathy and lack of engagement in the selection of the initiatives. Finally, organizational myopia may occur from concentrating on short-term issues to the exclusion of long-term strategies. When managed well, organizations can experience outstanding outcomes. Organizations that emphasized group affiliation, teamwork, and coordination achieved higher levels of quality

improvement than those with formal structures, regulations, and reporting relationships (Scott et al., 2003).

Transforming the organizational culture through change management.

To successfully transform an operational structure, organizations must also transform the organizational culture. Project plans for significant organizational changes or consolidations must include change management strategies and resources to align the culture, values, people, and behaviors in the new or changed environment. The goal is to engage the workforce impacted by the organizational change at the level of the individual employee. In this way, the organization will enhance the likelihood of preserving their unique values and sense of identity while creating a culture of commitment and performance (Jones, Aguirre, & Calderone, 2004). The change plan must include a readiness assessment for the proposed change to assess key people issues and identify the presence of employee fear, uncertainty, and resistance. These behaviors are common but detrimental to the desired outcome (Change management, 2014).

The success of this project was directly linked to the standardization and centralization of functions that had been decentralized for 15 years or more. Recognizing the vulnerability of this project for resistance due to the change in authority and decision-making for select community benefit functions, the GE CAP methodology was used to guide the project plan due its attention to the cultural aspects of introducing a change.

Setting

Organizational and market assessment.

Providence owns or manages 34 hospitals across Alaska, Washington, Oregon, California, and Western Montana. Each hospital is accountable for providing uncompensated services within the community that meet or exceed the hospital's tax obligation, if deemed a

taxable entity. Each hospital has an individual that is accountable for community benefit functions. In total, 11 individuals fulfilled this role. There is broad variation in terms of community health expertise, titles, and scope of responsibility among the community benefit leaders.

Geographic implications.

As depicted in Appendix A, the distribution of Providence's 34 hospitals ranges from remote rural settings, for instance Kodiak, Alaska, to urban markets, such as Los Angeles and Seattle. The vast geographical distance created a physical barrier for routine in-person interactions among the community benefit leaders.

Providence designated each of the five states where hospitals are located as a unique "region" with operational oversight by a regional chief executive and administrative council. Community benefit leaders are typically located in the hospital for which they manage the community benefit function and rarely travel to other entities. The exception is when a leader has accountability for more than one hospital within the region.

Accountability for community benefit functions.

Each regional chief executive has the management accountability for compliance with the IRS community benefit requirements for the hospital within their region. The operational responsibility is delegated to the hospital community benefit leader. Each region has structured the community benefit function differently.

The Alaska region has one community benefit leader who is responsible for one urban facility and three rural entities. That individual has other responsibilities in addition to community benefit.

In the Washington region, five individuals oversee the programs for 14 facilities, three of which are critical access hospitals. Two of the individuals are dedicated to community benefit full-time and three have other responsibilities. The individuals in Washington region have hospital-based teams to complete their duties; however, there is no region-wide structure or venue for them to network or collaborate.

The Oregon region has formed a community health division that is comprised of a staff of 4.0 FTE. The executive director of the division is accountable for community benefit functions for all 10 hospitals in the region. This region has the greatest level of integration and coordinates the community benefit functions on a region-wide basis.

The California region has two community benefit leaders to oversee the functions of six hospitals. The leaders conduct their work independently; however, they have a strong personal and professional relationship and collaborate routinely on an informal basis. The leaders are dedicated full time to the roles; although, they may also assume other duties when capacity allows.

In the Montana region, one community benefit leader oversees one urban and one rural facility. This individual has accountability for a breadth of other responsibilities as well.

Competency implications.

Prior to the launch of the project, the community benefit leaders from each region had not met in-person nor collaborated on a common initiative. In addition, they had a diverse array of backgrounds and community health knowledge. Therefore, it was important to understand what support or resources would be required for each community benefit leader to be able to meet organization-wide standards.

Resource implications.

The community benefit leaders had varying resources to support community benefit functions. Historically, each leader conducted the required community assessments and improvement planning with the resources available at the local level. Leaders who were dedicated full time to community benefit functions were more likely to lead or be highly engaged in all components of the process. Individuals that had multiple other responsibilities were more likely to contract with a vendor for all or part of the process. The most frequent request for external support was to meet data collection, analysis, and report writing obligations.

Increasingly common was the engagement of the community benefit leader in community assessments led by the local health department or other community stakeholders. This created opportunities to share knowledge and resources and to deepen relationships with community partners. If the community benefit leader participated in a community-wide process, the IRS requires that they also complete a hospital-specific report and implementation plan.

Systems and structures.

Prior to the project, each of the community benefit leaders worked independently from their peers. About 50% of the leaders reported to the local mission executive and the other leaders were in a planning or clinical division. All authority for the community benefit function and allocation of resources was at the local hospital level. There was a lack of standardization of tools and processes, and there were no shared resources across the organization. Networking occurred through informal relationships.

Engagement of subject matter experts.

Individuals accountable for community benefit functions and representatives from supporting divisions were invited to participate on a Council to shape the vision for community

investment and to participate in initiatives to create efficient and effective processes. This was the first opportunity for this group to work together, and given the importance of team building, a blend of in-person and telephonic meetings were held to balance the need for face-to-face relationship building and the efficiency of telephonic sessions. The Providence Senior Leadership Council reviewed and approved all Council members, thereby giving all individuals the authority to participate fully, including required travel and expenses.

Planning the Intervention

The intervention.

In 2013, Providence restructured its operational divisions to achieve greater efficiencies in response to national health reform legislation. That fall, during a strategic positioning process, Providence's Board of Directors endorsed *Creating Healthier Communities, Together* as the core organizational strategy. This provided the impetus for the creation of a Community Partnerships Division designed to integrate six external facing departments: community benefit, community engagement, advocacy, government affairs, philanthropy, and international outreach. Prior to this time, each department reported through a different division, and the staff rarely collaborated on initiatives. By incorporating the departments into a common division, Providence's Senior Leadership Council believed it would optimize the synergy across the functions and allow for the alignment of strategic priorities.

Acknowledging a deep understanding of the community's needs was foundational to improving community health. The Senior Leadership Council determined that the first area of focus was to enhance the community benefit function. This required three specific efforts: (a) to create a governance council for community investment to provide guidance and oversight for changes to existing processes and structures, (b) to reduce variation in the function across the

organization by standardizing or centralizing core functions, and (c) to determine a methodology for measuring and reporting the impact of the community health improvement strategies.

The Senior Leadership Council determined the scope of the project warranted a full-time program executive; therefore, in late 2014 the Senior Director for Community Partnerships, the author of this document, assumed leadership for the project. In this role, the Senior Director designed and led the project, oversaw and staffed councils and work groups, sought and distributed resources, and submitted progress reports to the Senior Leadership Council. A project plan was developed that incorporated the Change Acceleration Process (CAP) methodology to optimize success of the project. The Project GANTT chart presents the project components (Appendix D).

CAP step 1 and 2: leading change and creating a shared need.

The first two elements of the CAP occurred simultaneously. The two steps, leading change and creating a shared need, were addressed by the development of a business case that illustrated the current level of community investments, measurable changes in health improvement, and expanding IRS regulations. Upon review of the business case, the Senior Leadership Council approved the creation of a governance council for community benefit under the leadership of the Senior Vice President Community Partnerships, who was designated as the Executive Sponsor.

The Executive Sponsor provided guidance to the Senior Director in the design of the project and was a resource to resolve issues or barriers. The Senior Director provided leadership for the design and execution of the project plan; and was certified in several GE change management methodologies, including CAP.

The Senior Director invited individuals with expertise in community benefit, finance, nursing, mission, planning, and operations to participate on a governance council. The proposed council roster was approved by the Senior Leadership Council prior to the receipt of an invitation. The Senior Leadership Council endorsement provided each person the authority to be a voting member on the council and assured that they were provided the time and resources to fulfill their role.

The Senior Director led a strategic visioning process with Council members resulting in a three-year community investment strategic framework. Upon prioritization of strategies, the Council was expanded to include subject matter experts to establish and implement tactics. Work groups were established for each strategic initiative and all work group members participated on the governance council.

To prepare individuals for participation on the Council, the Senior Director held an orientation that provided an overview of the project and desired outcomes, the proposed approach for implementing the work, and the role of each member. Because the Council members are located across five states, the orientation was conducted by webinar supported by Providence collaboration technology.

The Council members had a broad range of experience in participation in organization-wide initiatives. About a third of the members were seasoned project managers and had extensive experience as team leaders and/or members and in the application of the CAP process. A second third had some experience on project teams, typically at the local or state-wide level. This group required minimal orientation to the change management process. The final third were experiencing their first organization-wide decision-making group, therefore, the Senior

Director conduct 1:1 telephone calls to each person in this group to discuss their role and the CAP process in order to elevate their confidence and effectiveness in their role.

Cost / benefit analysis.

A return on investment (ROI) analysis was completed for three project scenarios utilizing the ROI tool incorporated into the Agency for Healthcare Research and Quality Indicators Toolkit (AHRQ, 2015). This tool was designed to determine the financial return for an investment in a new program, intervention, or process. The calculated ROI was reported as a ratio to show the financial gain (or loss) a hospital can expect for each dollar it invests in the project. Ratios that exceed 1.0 indicate the project will have a positive ROI and warrant further evaluation and/or implementation.

The first scenario assumed Providence would continue its current workflows related to community benefit functions. Each hospital would independently conduct Community Health Needs Assessment and Implementation Strategy activities, as well as report community benefit investments directly to the IRS via their annual 990 filing processes. In addition, no new collaborations between or among hospitals would occur.

A second scenario allowed for the establishment of standard tools and processes for Community Health Needs Assessment and Implementation Strategy activities across the organization; however, the accountability and authority for the conduction of the activities remained at the hospital level. This option included the development of standard templates for Community Health Needs Assessment reports, a standard rubric for prioritizing health improvement opportunities, standard and/or centralized data collection and storage, shared analytic and communication resources, and standard report templates.

The third approach considered was to centralize the entire Community Health Needs Assessment and Improvement Strategy function, along with the hiring of an executive to provide strategic leadership and operational oversight into a division at the corporate level with the accountability and authority for community benefit activities organization-wide. As in the second scenario, this included standard templates for Community Health Needs Assessment reports, a standard rubric for prioritizing health improvement opportunities, centralized data collection and storage, analytic and communication resources, and standard report templates. Community benefit staff would be located on-site at the hospital to develop and nurture relationships with community partners and to manage health improvement initiatives; however, their formal reporting relationship would be to the corporate office.

To calculate the net returns for each scenario, five categories of costs were evaluated: personnel, consulting, analytic support, communication support, and compliance. Because Providence's community health assessments occur on a 3-year staggered cycle, the analysis was based on three years of expenses. As such, the current expenditure for each category was estimated and annualized for a 3-year period. A 3% inflation rate adjustment was applied to the values for Years 2 and 3. All assumptions for the existing and project costs are presented in Appendix E: Project Pro Forma.

Nine categories of costs were included in the project implementation and operational costs calculations: personnel, in-person meetings, virtual meetings, supplies, data fees, training, information systems and data management, analytic support, and communications. Total costs were offset by personnel salary and benefits currently funded in 2015 operating budgets in order to determine the project's net expenses. The costs were organized by stage of project, including

planning, training, start-up, and three years of operation. Upon completion of the net return and cost calculations, the ROI was determined for each scenario.

Scenario 1, the approach that assumed the status quo upon completion of the basic planning activities, resulted in a net return of $0 and planning costs of $13,900 (ROI = $0 / $13,900 = $0). The decision to halt further activity at the close of the planning period is congruent with an ROI measure that indicates that there will be no return ROI in this project. The $13,900 expended centered on meeting time, travel, logistics, and supplies and was justifiable if the effort resulted in information for enhanced decision making. While this option did not result in financial risk, it was determined that there was organizational risk of not addressing potential compliance issues.

Scenario 2 assumed the establishment of a governance structure and the introduction of standard tools, processes, and shared resources across the organization. In this scenario, the accountability for the conduction of Community Health Needs Assessment and Implementation Strategies remained at the hospital level. To determine the net return for this scenario, the existing personnel estimates were unchanged; however, the use of external consultants was eliminated and access to communication and analytic support was availed through a new shared resource structure. This option projected a 3-year net savings of $621,520 for those functions.

The cost projections for Scenario 2 included expenditures in planning, training, start-up, and the first three full years of operation. The planning and start-up periods contain the highest costs due to the intensive action planning by highly compensated work group members who were actively engaged in the design and execution of the project. While their time was expensive, their involvement and buy-in had long term benefits for the success of the project. This scenario allowed for a continued maturity in the type and quality of data incorporated into the health

improvement planning. While the standardization and management of public data was the priority in Year 1, $10,000 dollars was included in Years 2 and 3 to acquire proprietary data sets to enrich decision making. An additional assumption in this option was that the project budget would include funding for information services support, analytic expertise, and communication resources, thereby alleviating the acute facilities of these expenses. The project costs for this scenario, once normalized for previously budgeted personnel expenses, was $167,680 (ROI = $621,520 / $167,680 = 3.71). This ROI was indicative of a strong financial return by investing in this project. In addition, this scenario offered a solution to mitigate compliance risks.

Scenario 3 shared many similar features with the Scenario 2, with core difference being the centralization of employees leading Community Health Needs Assessment and Implementation Strategy efforts into a common division. For that reason, the personnel components of the net returns and the project cost calculations differ from Scenario 2, otherwise all assumptions remain the same. This option assumes that the conduction of community benefit activities will continue to occur on the 3-year staggered basis and that an individual at the local level will be accountable to support and enrich relationships with community partners. While the staffing level will remain relatively close to current ratios of 0.5 FTE / Community Health Needs Assessment, the competency of the individuals in the new model will be elevated as a result of focused development efforts. In addition to centralized staff, this option allowed for the recruitment of a community investment executive to provide strategic leadership and operational oversight. The net return for this option was $1,272,464 and project costs of $1,098,441, resulting in an ROI of 1.16 (ROI = $1,272,464 / $1,098,441 = 1.16). This ROI suggested that the project outcomes will likely cover the project costs within the first three full years of implementation, but will not return significant financial savings. However, the introduction of a

strategic leader to oversee the execution of existing strategies and the development of new innovations would position Providence well in achieving its goals.

The first scenario was determined to be the least viable due to the outstanding compliance risk that may result from the selection of this choice. Scenario 2 offered a strong financial return, increases in organizational efficiencies and effectiveness, a focus on compliance, and minimal disruption to individual roles and responsibilities, thereby minimizing resistance to the change. The third scenario allowed for the significant organizational enhancements and improvements in employee competency and was the preferred option for long term sustainability of a community investment strategy. However, this scenario was deemed to be met with the most resistance due to the change in authority and accountability for the community benefit function. Therefore, the project was designed to proceed with the Scenario 2, with the long-term goal of pursuing the centralization of the community benefit function in future years.

Responsibility and communication plan.

The Senior Director identified five internal stakeholder groups for strategic messaging related to the project: chief executives, community benefit leaders, risk and compliance leaders, finance leaders, and health intelligence and clinical data analysts. Each stakeholder group was committed to the organizational strategic vision, recognized the dramatic variation in the existing processes and outcomes, and understood the importance for IRS compliance.

The chief executives desired an overview of the business case for the project, the relevant human and financial implications, the timeline for implementation, and the impact to their local hospital or region. They also wanted to be assured that their community benefit leader was engaged in the process and supported the project plan. The community benefit leaders needed to be confident their executive supported the project and would allocate the resources to implement

new processes. The finance, risk and compliance, and analytic leaders needed to be acknowledged as partners and be engaged in a timely and meaningful manner. The core messages for each stakeholder group were highly aligned; however, the delivery of the message was tailored to address the special interests of each group (Appendix F).

The communication rollout began with a presentation to the Senior Leadership Council to establish leadership support and create a compelling need for the project. This was followed by in-person meetings between community benefit leaders and their chief executive to socialize the concepts and to seek support or identify potential areas of resistance. The project was then communicated to all stakeholder groups. Once approval and resources were secured, ongoing updates were disseminated through established communication venues, including newsletters and email.

Implementation

Steps three through five of the CAP – shaping a vision, mobilizing commitment, and making change last – provided the framework for the project implementation efforts.

CAP step 3: shaping a vision.

The goal of this phase of the project was to ensure that there was a shared vision for the future state and that the desired outcomes were clear and understood. To achieve this goal, the Senior Director established an organization-wide Community Investment and Development Governance Council (Council) in January 2015 to provide strategic direction and vision for community benefit efforts and to oversee work teams charged with advancing strategic priorities. The Council was composed of key leaders in community benefit, nursing, medicine, finance, mission, and operations. The Strategic Leadership Council positioned this Council for success

by approving the Council membership and delegated authority during the project's planning phase (Appendix G: Council Charter).

The Council's first objective was to develop a strategic framework to guide community benefit initiatives and activities. This was completed in February 2015 during a two day in-person work session led by the Senior Director. During the first day, the Council members participated in a facilitated discussion and identified five strategic themes: (a) deepen connection of caregivers to community programs, (b) build enduring community relationships, (c) elevate local and national understanding of Providence, (d) leverage assets and investments to build healthier communities, and (e) secure sustainable resources to support core strategy. Once the strategic themes were delineated, the Council members were divided into small groups to brainstorm potential tactics relevant to one of the five strategy themes. Each small group had a designated facilitator who was responsible for leading the brainstorming process, documenting proposed tactics, and reporting out to the full group. On the second day, the full Council discussed the proposed tactics and came to consensus on those deemed to be high priority.

Over the following two months, each Council member was accountable to vet the proposed strategies and tactics with their colleagues and community stakeholders to solicit input and support. The Senior Director led bi-weekly email discussions throughout March and April with Council members to refine and finalize the strategies and tactics. The result was summarized into a one-page document, the Community Investment Strategic Framework (Appendix H). The engagement of the Council members in shaping the vision for community investment created buy-in to the strategies and desired outcomes. The strategic framework document served as an effective communication tool for the dissemination of the community investment vision and strategic priorities throughout the organization.

CAP step 4: mobilizing commitment

Upon completion of the strategic framework, the next phase of the project was to standardize the community assessment and implementation planning processes and to centralize common data and reporting tools and templates. Because the changes directly impacted existing workflows and processes, it was important that individuals responsible for the work were able to contribute to the process. The CAP methodology defines this step in change management as mobilizing commitment, where stakeholders for the change are engaged in the process and resistance is identified and mitigated as appropriate.

To conduct the work, the Senior Director assigned Council members to lead or participate on work groups related to community health needs assessment processes and templates, data collection and analysis, communication, and compliance reporting. Individuals who were responsible for conducting any function related to the work groups were invited to join the Council, as these individuals were the most knowledgeable of the existing processes and highly invested in working toward an effective outcome. Also, Council members who chose to contribute to the strategic framework, but did not have the capacity to serve on work groups, were allowed to transition off the Council.

The Senior Director held a kick-off session for the work groups in April 2015. Members from five work groups spent three days at the Providence system office to work toward a set of deliverables agreed upon by the Council. Each work group had a designated leader who designed the process the group would follow to achieve their objectives.

Work Group 1 was responsible to establish a uniform approach to needs assessment and health improvement plans and had four deliverables: (a) develop standard definitions for community benefit functions, (b) recommend standard minimum specifications for inclusion in

community health needs assessment, (c) propose standard process templates for presenting community health needs assessment findings, and (d) design a standard process for health improvement planning. Work Group 2 was accountable to establish a uniform approach to data collection, storage, and analysis and had two deliverables: (a) identify standard data sources and efficient collection processes and (b) recommend processes that can be standardized or centralized. Work Group 3 was focused on the establishment of routine communications for internal, local, state, and national audiences and had four deliverables: (a) inventory best-practice communications related to community investment; (b) propose methods to strengthen caregiver understanding of community benefit and investments; (c) delineate a process to aggregate stories related to impact of community investment for advocacy and communication; and (d) develop a plan for routine communication to internal, local, state, and national audiences. Work Group 4 was responsible for developing a methodology to effectively measure the impact of community investments and had one deliverable: to evaluate existing measurement models and recommend an approach for Providence to pilot in 2017. Work Group 5 was accountable for establishing an efficient and compliant process for tracking and reporting community benefit and had two deliverables: (a) identify best practices for tracking community benefit expenses and (b) recommend standard processes for reporting community benefit.

On the first day of the work session, Work Groups 1 through 4 met independently on their assigned deliverables. For the second day, all work groups came together to present their progress toward each deliverable and to solicit feedback from the entire Council. This provided each work group the opportunity to get immediate input on the direction of their work, to discuss questions that arose within the work group, and to outline the necessary resources to advance the work. The third day of the session was dedicated to Work Group 5 discussions and decisions.

The group was co-led by a community benefit leader and a finance leader and included Council members along with finance leaders in accounting and financial reporting.

The 3-day kick-off session was effective for orienting each person to the purpose of their work group, to the expected deliverables and timelines, and to serve as a venue for organizing the work and rapid decision-making. The work group leaders were responsible for scheduling ongoing meetings with their group on a routine basis to complete their assigned deliverables by the late June in-person meeting.

The full Council met in June to evaluate the status of each work group's deliverables. Work Group 1 presented a standard process and template for presenting CHNA findings that was modeled after a document deemed as exemplar and compliant with all IRS regulations. Work Group 2 introduced a proposal for centralizing all data collection and analysis into a common function with oversight by internal data and research staff. Work Group 3 presented a concept for presenting community benefit stories and projects to external audiences and stakeholders. Work Group 4 recommended an organization-wide priority focused on mental health issues for community health investments. Work Group 5 discussed a standard process for calculating financial data for reporting. The recommended tools or approaches presented by each work group were approved by the Council and next steps to advance the work were outlined.

During July and August, the CHNA template was tested utilizing the results of a CHNA conducted in the Spokane, Washington community in the summer of 2015. Over the same time period, the Senior Director partnered with the Center for Outcomes Research and Analysis to develop a proposal for the centralization of data collection and analysis. Additionally, the Senior Director created an internal SharePoint website to post all tools and resources in a common location. The Council met by teleconference in August and revised the template and reviewed

potential tools for implementation planning and reporting. The final templates and tools were finalized in September 2015.

CAP step 5: making change last.

The fifth step in the CAP is to make the change last. This is accomplished by having visible and tangible reinforcements of the change. The SharePoint site was an important tool in visually illustrating the decisions and the accomplishments of the Council. As depicted in Appendix I: Community Investment and Development SharePoint Site, the site hosted the tools the Council created and provided links to internal and external resources. The Council members have authority to post documents and materials, thereby enhancing collaboration and the rapid spread and adoption of best practices. To support the adoption of the site, key documents, such as monthly agendas and meeting materials, as well as templates and tools, were posted onto the site and a link sent out to Council members to have them routinely go to the site and gain expertise in navigating the tool. For the initial year of the project the Senior Director served as the webmaster for the SharePoint site, however over time, the intent was to transition ownership to the communication liaison.

Planning the Study of the Intervention

The goal of the project was to organize Providence's community investment systems and structures to achieve the optimal community health improvement impact. This was accomplished by the completion of four strategic initiatives: (a) establishment of a community investment governance structure and strategic framework, (b) standardized community assessments and health improvement planning, (c) centralized data collection and storage, and (d) standardized reporting guidelines. Success measures were developed by the Council for each

strategic initiative and approved by the Project Executive Sponsor. The project was evaluated against pre-established success measures as each milestone was accomplished.

Gap analysis.

All community benefit functions were fully decentralized within Providence prior to the project implementation. Each hospital chief executive determined the manner in which functions were executed and resources allocated to community assessments, data collection and analysis, health improvement planning, and financial reporting.

The absence of uniformity in the community benefit leader role resulted in a broad array of skills and backgrounds among individuals designated to conduct the work. In addition, over 50% of the assessments were either outsourced or conducted in partnership with community stakeholders who provided the leadership for the assessment and analysis process. The IRS regulations dictate key factors that must be included in a Community Health Needs Assessment; therefore, while the process may have varied from hospital to hospital, all hospitals addressed a common set of issues. However, the way the information was documented varied dramatically in depth of content, presentation of findings, and inclusion of supporting documentation. Data collection and analysis varied significantly among the facilities. Primary data sources and collection methodologies were the most consistent. Interviews, online surveys, focus groups, community health surveys, and written surveys were the most common methods; however, the data collection tools differed across the states, making the findings incomparable across the organization.

The majority of the facilities incorporated secondary data from local public health departments, U.S. Census, state cancer registries, the American Community Survey, and local hospital data into their community assessment efforts. Less than half of the facilities also

included data from one or more of 31 additional secondary data sources, such as the Urban League, Gallup data, Behavioral Risk Factor Surveillance System, Thomas Reuter, and state vital statistics.

Upon completion of the community assessment, each facility determined which initiatives they would lead, participate in, and/or fund based on identified community needs. There was an absence of coordination of initiatives across the organization and a lack of a repository of initiatives to allow for replication. Given the differences in areas of focus and methodologies for implementing interventions, it was difficult to measure the overall impact of the collective community health improvement efforts. In the absence of an impact measure, total dollars spent on community benefit was used to track performance.

The IRS regulations require that community benefit expenses are documented and reported on an annual basis. The community benefit leader was responsible for tracking expenses related to assessment and the implementation of initiatives. The hospital finance officer was accountable for tracking expenses related to shortfalls in reimbursement for government programs, research and education, and bad debt. There were varying levels of understanding of the specific services that should be included in each category. In some cases, the community benefit officer worked closely with the finance officer, in other cases their only interaction was through email communications. Appendix J: Project Gap Analysis presents the current state, the desired future state, and the proposed intervention.

Critical milestones.

The Senior Director measured successful progression of the project by the achievement of nine critical milestones. As depicted in Appendix D, the first milestone, Senior Leadership

Council approval for the project and designation of Executive Sponsor, occurred in November 2014, and the remaining eight milestones were accomplished over the following 10 months.

The second milestone, the establishment of a Community Investment and Development Council, was completed in January with the finalization of the Council charter and membership. Milestone three, the creation of a Community Investment Strategic Framework, was achieved in March after a 2-month process that included strategy development, socialization, and refinement.

At this point in the project, Council members were offered an opportunity to stay engaged on the Council and advance the identified strategies or to transition off the group. The subject matter experts in nursing, medicine, and mission requested to be reclassified as ad hoc members, and new individuals were invited to participate on teams focused on milestones four through nine.

In June, the fourth milestone was achieved – the creation of a standard CHNA process and template approved for pilot testing. The process and templates were implemented for two CHNAs conducted in the Spokane, Washington community and refined based on feedback from the community benefit leader conducting the assessments, the hospital management team, and the Council. Approval by the Council for the refined document was the fifth milestone for the project.

In a parallel process to the standardization of the Community Health Needs Assessment tools, the sixth milestone was accomplished in June by securing Council approval of standard data sets to be incorporated into the assessment process. The Council also agreed to centralizing access to the data sources.

The seventh milestone – the development of a SharePoint site – was completed in September and served as the portal to access the Community Health Needs Assessment templates, data sets, and links to internal and external resources.

The eighth milestone – the determination of mental health as a strategic priority for organization-wide focus – was accomplished in June and approved by the Senior Leadership Council and board of directors in July.

The final milestone – the documentation of financial reporting guidelines for 2015 IRS reporting – was achieved in October after a 5-month process that was co-led by community benefit and finance leaders. The outcome of that milestone was a policy and procedure document that outlined the expenses eligible for reporting, data sources, and methods of calculation.

Intended changes and improvements.

With the heightened importance of community benefit efforts, Providence desired an organization-wide structure to provide governance and coordination of strategic initiatives. The formation of the Community Investment and Development Council fulfilled that goal. The Council served as the venue for cross-divisional collaboration of strategy development and oversight.

In order to achieve an increase in the reach and impact of community benefit functions, the creation of standard processes for the assessment of community health needs was required. A work group was commissioned to propose a uniform approach to a needs assessment and health improvement plans. To enhance the efficiency of the assessment process, a work group was assigned to identify a set of core data sources and efficient collection processes that could be organized in a central location. This work group also explored opportunities for shared analytic

expertise in order to increase decision quality of selecting health improvement initiatives. Lastly, to ensure compliance with all regulatory requirements, a work group was dedicated to the development of a standard reporting policy and procedure. Each of the work groups had a designated leader and provided a status update at each Council meeting.

Impacted staff and stakeholders.

The individuals directly impacted by the project were the community benefit staff and the finance officers that were accountable for community benefit reporting. The Senior Director extended an invitation to each impacted individual to participate on the Council or a work group so they felt engaged in the process and could express their support and/or concerns for proposed changes. Through their participation, barriers were identified and mitigated throughout the process, and there was minimal resistance for the change.

The Council and work group members had varying levels of experience for change. While all individuals had experienced and responded to unprecedented levels of change within their local hospital or region, this is the first time the majority of Council members had contributed to decisions that would be implemented organization-wide. To support their expanded decision-making authority, a council charter was developed and approved by the Senior Leadership Council that outlined their level of authority, which was reinforced during the orientation to the Council session. To build confidence in decision making, the Council was asked to make several small decisions to create trust among the group before more impactful discussions were introduced. In that Providence organizes the majority of large initiatives using the CAP change management process, the Council members were familiar with how the project would be managed and only needed to adjust to the magnitude of the decisions.

Project leadership.

The Senior Director provided the leadership for the project. This individual had over 25 years of leading large initiatives and had worked extensively with leadership teams for the past 10 years. The Senior Director was certified in the Change Acceleration Process and Work Out, a complementary change management process developed by GE. The Senior Director's experience in working in several different Providence communities, coupled with existing relationships with senior leaders across the organization, provided an insight into the unique cultures, challenges, and opportunities within each Providence community. This experience was valuable in shaping strategies that would have the greatest consensus and support.

Project support and resources.

Three elements were instrumental to the success of the project. The first was the compelling business case to protect the organization's tax-free status by demonstrating community benefit in excess of tax obligation. The second was committed leadership to provide direction on the project and allow for the Council and work group members to fully participate. The third was the designation of the Senior Director to organize and lead work sessions and provide the staff support to advance the initiatives.

Methods of Evaluation

The achievement of the success measures was determined by the Community Benefit Governance Council membership vote. Each member had an equal vote, and individuals who were not able to participate in the approval process were encouraged to invite a staff member to participate in the meeting on their behalf. One of the deliverables was a governance structure, that is, the Council, and it was deemed to be completed once the charter had been approved by the Senior Leadership Council and the members held their initial meeting. The deliverables that

were material documents or tools were considered complete upon approval of the content by the Council.

Two of the outcomes were new processes and were deemed complete when they were mature enough for field testing. There was consensus among the Council members that the changes in processes will evolve over a period of time and must be appropriate for diverse settings and locations. Because the conduction of Community Health Needs Assessment only occurs every three years, multiple years will pass before all locations will provide community-specific feedback; thus, refinement of the processes will be ongoing.

All tools and processes were evaluated for compliance with IRS regulations. The tool to conduct the compliance evaluation was the Catholic Health Association of the United States' Assessing & Addressing Community Health Needs: A Summary of New Requirements & Recommended Practices (CHA, 2015). No other formal tools were used in this aspect of the evaluation process.

Current state.

As depicted in the Project SWOT analysis (Appendix K), Providence was well-positioned to effectively execute this endeavor. The project was aligned with the organization's core strategic priority, and Providence had a commitment to its community investment strategy. The community benefit leaders were actively engaged in the design of the project and demonstrated a willingness to collaborate across the organization. Importantly, the executive leaders were seeking enhancements to the existing processes.

Several barriers had to be addressed to achieve the specified project goals. The organization was undergoing an unprecedented amount of change, and even small projects were met with resistance due to widespread organizational change fatigue. In addition, several internal

business partners, including finance, marketing, communications, and information systems, were critical to the execution of the project and had to support the project goals and timelines.

Return on investment plan.

As depicted in Appendix E, a robust ROI analysis was conducted during the planning phase of the project that suggested a positive return on investment for the financial expenses associated with three different scenarios for the project. The full impact of the project will not be realized until 2018 due to the 3-year cycle of the IRS requirements.

The first scenario, maintaining the status quo upon completion of the project planning activities, resulted in a net return of $0 and planning costs of $13,900. This option did not result in significant financial risk; however, it was determined that there was a high organizational risk of not addressing potential compliance issues. Therefore, this option was eliminated.

A second scenario allowed for the establishment of standard tools and processes for Community Health Needs Assessment and Implementation Strategy activities across the organization, with the accountability and authority for the conduction of the activities to remain at the hospital level. This option projected a 3-year net savings of $621,520 and project costs of $167,680 and was indicative of a strong financial return by investing in this project along with a solution to mitigate compliance risks (ROI = $621,520 / $167,680 = 3.71).

The third approach shared many similar features with the prior scenario, with the core difference being the centralization of employees leading Community Health Needs Assessment and Implementation Strategy efforts into a common division. In addition, this option allowed for the recruitment of a community investment executive to provide strategic leadership and operational oversight. The net return for this option was $1,272,464 and project costs of $1,098,44, resulting in an ROI of 1.16 (ROI = $1,272,464 / $1,098,441 = 1.16). This ROI

suggested that the project outcomes will likely cover the project costs within the first three full years of implementation but will not return significant financial savings. However, the introduction of a strategic leader to oversee the execution of existing strategies and the development of new innovations would position Providence well in achieving its community health goals. Anticipating that this option would be met with high resistance due to the change in authority and accountability for the community benefit function, the project was designed to proceed with the second scenario, with the long-term goal of pursuing the centralization of the community benefit function in future years.

Analysis

The achievement of the success measures was determined by the Community Benefit Governance Council membership vote. The first deliverable, a governance structure, was deemed achieved upon approval of its charter and the conduction of the initial meeting. The second and third deliverables were the standardized process and data sets for the Community Health Needs Assessment. This was considered complete when the proposed data were collected, analyzed and an assessment process was field tested by the community benefit leader in Spokane, Washington. All tools and processes were evaluated for compliance with IRS regulations. The tool to conduct the compliance evaluation was the Catholic Health Association of the United States' (CHA, 2015) Assessing & Addressing Community Health Needs: A Summary of New Requirements & Recommended Practices.

Consensus among Council members was that all success measures had been achieved, however, there was agreement that the testing of the tools and processes was limited to one community which may or may not be representative of all Providence communities. Therefore,

the Council committed to refining the tools based on feedback from stakeholders as assessments are conducted in the future.

Results

Evaluation and Outcomes

CAP step 6: monitoring progress.

The CAP's sixth step is monitoring progress. This is effectively completed through an evaluation of progress against the project goals using a pre-determined set of measures. The goal of the project was to organize Providence's community investment systems and structures to achieve consummate community health improvement impact and evaluate against four measures:

1. The establishment of a community investment governance structure and strategic framework by March 2015,
2. The development of standardized processes and templates for community assessments and health improvement planning by June 2015,
3. The delineation of uniform data sources and centralized storage by June 2015,
4. The creation of standardized reporting guidelines that fulfill IRS requirements by September 2015.

Success Measure 1: Governance structure and strategic framework. The achievement of the first success measure occurred with the launching of the Community Investment and Development Council in January 2015. The first priority for the Council was to develop a strategic framework to guide community benefit priorities. Council members developed a proposed framework in January and socialized the concepts with local internal and external stakeholders. The document was then refined based on stakeholder feedback and approved as final by the Council in March 2015. This success measure was deemed complete by a vote of the Council.

Success Measure 2: Standardized community assessments and implementation planning. A Community Health Needs Assessment process and template was developed and determined to be in compliance with IRS requirements. The process was followed, and the template was used to present the results of two community assessments conducted in summer 2015 in the Spokane, Washington community. Template refinements were made to enhance ease of use and incorporate feedback from local leaders and Council members. The template was then approved by Council vote as the organizational standard process for all 2016 community assessments. The success measure was considered to be achieved.

Success Measure 3: Uniform data sources and centralized storage. A proposed core data set for inclusion in the community assessment process was approved by the Council in June 2015. A SharePoint website was developed in September 2015 to host links to the data sources and other community benefit related resources. This success measure was considered fulfilled by Council vote.

Success Measure 4: Standardized reporting. The IRS requires non-profit hospitals to report their community benefit activities in the fourth quarter of each calendar year. Hospitals must report five categories of expenses that directly benefit the community: (a) unfunded portion of medical care for Medicaid patients, (b) free and discounted care for patients in need, (c) community health grants and donations, (d) education and research programs, and (e) the cost of clinical and social services provided at a financial loss and not available elsewhere in the community. In addition to the financial reporting, hospitals must also submit a narrative report of actions taken to address the significant health needs identified in the most recent Community Health Needs Assessment. The narrative report requirement was introduced in 2015.

A workgroup co-led by community benefit and finance leaders developed a policy and procedure document that outlined the data sources and calculation methodology for completing the financial section of the IRS 990 report. The document was approved in September 2015 to be used for the preparation of the 2015 filing. The Council members designed a format for the narrative section of the 990 report to be used uniformly across the organization. The format was approved by the Council in September 2015, and the success measure was considered met.

Evaluation tools.

The resource utilized to evaluate compliance with IRS guidelines was the Catholic Health Association of the United States' (CHA, 2015) Assessing & Addressing Community Health Needs: A Summary of New Requirements & Recommended Practices. No other formal tools were required in the evaluation process.

Future evolution of the project.

Community benefit was a well-established function within Providence; however, executing initiatives in collaboration with other community benefit leaders and divisional partners was in its infancy. The Council members acknowledge that the processes and tools they created will evolve over a period of time and must be modified as appropriate to meet the unique needs of the various Providence settings and locations. Because the conduction of Community Health Needs Assessments only occurs every three years, multiple years will pass before all locations will provide community specific feedback.

The Council remains committed to the goal of the project and the achievement of the success measures within the proposed timeline. Tightly structured agendas and work groups with clearly outlined responsibilities and deliverables were instrumental in maintaining focus. A

supporting factor was the conduction of 2-day work sessions that were highly structured and resulted in a high level of productivity and momentum toward the goal.

Three unplanned opportunities influenced the project. The first was the change in Council membership after the creation of the strategic framework. It is unusual to have changes to a Council mid-year; however, the individuals felt their greatest contribution was to contribute toward the vision and strategies for community benefit efforts and that others would be more effective in the implementation phase. While this allowed for the Council members to invite additional individuals with the skills or competencies to advance strategic priorities, it did require the Council to pause and take time to reform as a new team.

Secondly, a work group was charged with proposing a process for developing a community health index. By mid-year, the Senior Leadership Council and clinical executives had determined that mental health was a leading issue in all of Providence's communities and was worthy of an organization-wide plan. Concurrently, the work group identified mental health as a prominent health concern based on the most recent Community Health Needs Assessment. Therefore, efforts to work towards a community health index were redirected toward planning for an organization-wide approach to impacting mental health issues.

The third evolution in the project was an opportunity to centralize all data collection and analysis functions into a single division that would be under the direction of Providence's Center for Outcome Research and Education (CORE). This division offers data collection, analysis, and evaluation capabilities and has an interest in expanding its community health improvement expertise. A proposal to provide data collection and analysis for the 2016 community assessments is under consideration by the Senior Leadership Council.

Leadership engagement and support.

The Senior Leadership Council formally supported the improvements by designating the project an organizational priority and authorizing executive sponsorship and the essential financial and human resource support to achieve the project outcomes. The Senior Leadership Council reviewed quarterly status reports submitted by the Senior Director and were available to intervene if the Council was not able to resolve issues or major barriers.

Alternative strategies considered.

The project strategies were selected based on their importance in increasing community benefit process efficiency and effectiveness and were deemed only minimally disruptive organizationally. Over time, future efficiencies may be gained by centralizing the community benefit function into one division, while maintaining a local presence for ongoing engagement with community partners with the overall authority and decision making in a central office. This is much more controversial and would require a longer timeline to evaluate the impact, identify and resolve barriers and issues, and determine if the outcomes outweigh the organizational disruption.

Effects of the project on staff and workflows.

The Council members felt empowered to develop and implement strategies that are designed to optimize the impact of the work they lead. In that the accomplishments were only piloted in one community, the majority of individuals had not been personally influenced by the project. Yet, there is general agreement that the tools would enhance their work. Additionally, the Council members established strong working relationships over the course of the project and have developed a network of peers for information sharing and problem solving outside of Council meetings.

Risk assessment and mitigation.

As designed, the project presented minimal organizational risks. The greatest area of concern was the potential for resistance to standard processes or templates by the local community benefit leader. Because the authority for community benefit resides at the local level, the Council does not have the authority to ensure compliance with agreed upon tools. To address this issue, all community benefit leaders were invited to be engaged in the Council and to approve the proposed tools and processes. When resistance was identified, private meetings were scheduled to discuss perspectives and possible solutions.

A second area of risk was the achievement of all project milestones over a 10-month timeline. To position the Council for success, a project leader was dedicated to facilitating the work sessions and staffing the work groups between meetings. To optimize the productivity of the Council and work group sessions, the CAP methodology was followed, meeting agendas were designed to achieve milestones, and teleconferences were replaced with in-person work sessions.

Unintended consequences.

The Council offered a venue to bring individuals together from across divisions to create a common vision for community health improvement. As leaders across the organization were informed of the accomplishments of the Council, they identified opportunities for collaboration. By August 2015, leaders from human resources, advocacy, and government affairs joined the Council to explore opportunities to align workforce and advocacy strategies to accelerate community health improvement impact. The alignment of strategic priorities across the organization was the intent of the establishment of the Community Partnership Division goal;

and, it is noteworthy that with the creation of a venue for collaboration, alignment has begun to evolve organically.

Discussion

Summary

Key successes.

The project was considered successful from several perspectives; the first being the completion of all project outcomes within the targeted timeframe. The establishment of a governance structure and the standardization of core community benefit processes across 34 hospitals were instrumental in providing a solid foundation to enhance efficiency and effectiveness of community benefit functions. In addition, the standardization of reporting processes ensured compliance with IRS requirements for non-profit hospitals. The successful completion of this project was empowering to the Council members and showcased their ability to make important contributions toward core strategies when working in collaboration across the organization.

Second, the Council served as a venue for relationship building among community benefit leaders. This allowed for the sharing and spreading of best practices, as well as the acceleration of expert-to-expert (E2E) issue identification and problem solving.

Lastly, the Council served as the forum to engage cross-divisional leaders to identify opportunities to align strategies related to creating healthier communities. The community benefit leaders began to work in partnership with their colleagues from strategy, advocacy and government affairs, as well as clinical and human resources to create organization-wide synergy in consummate community health impact.

Key findings and lessons learned.

The noteworthy lessons learned relate to the manner in which the project was managed. Initially, the intent was to establish a governance Council that would meet once in-person for an

orientation and then conduct all future meetings and work sessions virtually, supported by organizational telephonic and webinar technology. Within two months, it was determined that the group was much more productive when the meetings were in-person. For that reason, the meeting schedule was modified from bi-monthly, two-hour webinars to two-day, in-person work sessions that were held every six to eight weeks.

The change in schedule resulted in heightened productivity, as well as improved decision quality and buy-in for the work group recommendations through face-to-face discussions and debate. Also, given that the Council members were located over five states, the in-person meetings provided an opportunity to network and to establish personal and professional relationships that are unlikely to occur during virtual meetings. As a result, the Council members created a higher level of trust between one another.

A second lesson learned was that the Council members were unprepared for the pace of decision making. At first, some Council members were hesitant to make a decision knowing that it would have organization-wide implications. The members were assured that the Senior Leadership Council had given them the authority to participate in the decision making and would support their opinions. The members were encouraged to have a team member participate in meetings if they were not able to attend in order to have a quorum for approving work group recommendations. For critical decisions, the Senior Director followed up with members not in attendance to discuss the rationale for the decision to increase acceptance of the outcome.

Hardwiring the change.

Three strategies to hardwire the change were implemented. The first was the development of a SharePoint site to ensure easy access to the standard tools, templates, and resources approved by the Council. This eliminated barriers to locating the resources and the

temptation to develop new or different processes. The second strategy was to provide routine updates to the Senior Leadership Council to inform them of decisions made and to seek support for implementation at the local level. Lastly, and most importantly, the project engaged key internal stakeholders on the development of the project's goal and objectives. Through participation on the Council or work groups, stakeholders had a voice in the determination of high priority initiatives and desired outcomes. Their engagement enhanced buy-in and greater acceptance of the change.

Emerging opportunities.

The outcomes resulting from this project are the platform from which community investments can be optimized. The standardization and centralization of community assessment, planning, and reporting will reduce variation in practice and provide the foundation for community health initiatives to be executed in an efficient and effective manner. The increase in productivity will allow for the reallocation of staff time toward deepening community partner relationships.

The Community Investment Strategic Framework provides the roadmap for strategic priorities to achieve greater reach and impact of investments. Each fall, the framework will be refined and key priorities will be selected for implementation the following year. While this is a standard cycle within the organization, the Council has the authority to initiate new initiatives at any point of the year, if they have capacity to manage the project and the necessary resources are available.

The key priorities for 2016 will be the implementation of the Community Health Needs Assessment processes and templates by the 20 facilities that are required to complete their

assessments by December 31, 2016 and to begin aligning community health improvement initiatives to address local mental health access and delivery issues.

Implications for nursing practice.

Nursing practice has been steeped in the care of individuals and their families. Traditionally, nursing care has been hospital-based and acute care focused. The delivery of care is transforming at lightning speed, and nursing care models must evolve to meet new consumer and regulatory expectations. Nursing has an opportunity to be a leader in the transformation, but it will require a commitment to expand nursing education and practice.

This begins with the incorporation of population health concepts into nursing school curriculum, coupled with education and training venues for nurses already in practice. In the interim, universities and health care organizations can introduce student / employee led groups focused on population health such as IHI's I-CAN Chapters. Ideally, population health courses would be offered to inter-disciplinary groups to reinforce the collaborative principles of population health.

Nursing care models must give attention to the upstream drivers of health. Nursing has an obligation to build on its long heritage of public health care and service in neighborhoods and community settings. Nurses must take leadership in assisting communities and health care providers in the identification of community health priorities and the execution of actionable plans. Additionally, nursing must practice to the top of their license and work along-side state licensing agencies to develop new or expanded roles to meet community needs.

Nursing ought to strive for collaborative relationships within the organization and throughout the community. Nurses must role model respectful relationships that are inclusive of all members of the care team, including the patient, family and other key stakeholders.

Finally, nurses in all settings must embrace evidence-based practices and share new and innovative approaches in advancing the health of communities. Nurses must find their voice and share their insights, publish their findings, and expand the pool of shared knowledge.

Dissemination Plan

The dissemination of the Council's efforts will be shared within the organization via existing communication venues, such as project updates and leadership newsletters. Communication of the new community benefit processes, tools, and resources will be disseminated by Council members to their staff during routine staff meetings and new employee orientations. A goal is to present the effectiveness of the governance structure and standardized community benefit processes to peer organizations in the future, once all hospitals have implemented the new processes, refinements are complete, and impact is measured. The Senior Director, moreover, will disseminate the outcomes of this project to external audiences through peer journal publications and presentations to academic and professional organizations.

Relation to other Evidence

Literature search.

The literature search to explore population health models and approaches was conducted by searching the key words *population health*, *population health models*, and *population health frameworks*. This search generated a broad array of articles, yet, few focused on population health models in the U.S. healthcare system. Rather, the majority of the literature described the way population health models were operationalized in Canada and Europe. A second search using different key words identified articles describing the public health models and frameworks more common in the U.S. The key words used were *public health models* and *public health frameworks*. Particular attention was given to frequently cited authors and their bodies of work.

Most notable were James Dunn, Robert Evans, Daniel Friedman, David Kindig, and Greg Stoddart.

MacDonald et al.'s 2013 article, *Embracing the Population Health Framework in Nursing Research*, was instrumental in depicting Canada's methodology for integrating population health concepts into nursing practice and, just as importantly, included an inventory of seminal articles related to population health models. Each accessible document recommended by MacDonald et al. was reviewed.

A comprehensive literature search on this topic was influenced by two conditions. The first was that there is very little scientific research related to the population health models; therefore, the search was weighted toward literature reviews and expert opinion. Second, the dearth of literature focused on population health models in the U.S. health system required the review of literature from other countries and the extrapolation of the information as it may apply to the way care is organized and delivered in the U.S. health system.

Barriers to Implementation/Limitations

Implementation.

The three prominent barriers to implementation were (a) creating changes to processes across 34 hospitals in five states, (b) varying levels of expertise and access to resources among the Council members, and (c) organizational change fatigue.

The geographic breadth of the organization created a physical barrier that impacted the implementation by restricting the frequency of in-person meetings. Yet, when the Council members met in-person, they were highly productive and also had greater engagement and dialogue. By Council members' request, the Senior Director modified the meeting schedule to increase the number of in-person meetings and decrease meeting frequency. The change in

meetings resulted in unplanned travel and lodging expenses that required leadership approval. The timeline for the completion of the project may have been at risk had the meeting structure not been changed.

The second barrier to the implementation was the diverse backgrounds of the community benefit leaders and the availability of local resources to support data collection and analysis. While each hospital would benefit from standard tools and templates, some areas of focus, such as data collection support were not a high priority for every community benefit leader. The challenge was to keep them engaged even if they felt the initiative would not bring them value.

Lastly, given the significant amount of change occurring throughout the organization, some of the leaders were experiencing change fatigue and did not feel they had the capacity and/or energy to lead or participate in new initiatives. This was true at every level of the organization; even the Senior Leadership Council recognized that the existing number of organization-wide projects had overextended leadership's ability to offer the support and attention the projects warranted. To address this issue, the Senior Director checked in routinely with the work group leaders and provided staff support for the initiatives to maintain progression of the efforts.

Organizational culture implications.

A noteworthy cultural implication for the project was Providence's transformation from a highly decentralized organization to one that values centralization and standardization of administration processes. The community benefit leaders that participated on the Council were accustomed to having full decision-making authority over all aspects of the function they oversaw. The standardization and centralization of select processes organization-wide was a new way of executing the work. Because the authority for the function remains at the hospital

level, it is only through influence that the Council can hold members accountable for complying with the processes that were created.

Uncontrolled organizational changes.

There were no organization changes that confounded the outcome of the project.

Interpretation

Observed versus expected outcomes.

There was little difference between the observed and expected project outcomes. The individuals who participated in all components of the project were professional and experienced. As a result, the outcomes were high quality, actionable, and allowed for greater efficiencies of current processes. As the tools and templates are disseminated over the next couple of years, they will be evaluated and refined to be effective for each community.

Readiness for change.

The CAP framework offered a methodology for evaluating the readiness for the change and attentiveness to areas of resistance throughout the project. As the endorsed change methodology within Providence, leaders and staff were familiar with the importance of CAP's first three steps: (1) gaining leadership support, (2) creating a shared vision, and (3) articulating a compelling need for change prior to launching an initiative. The successful completion of those steps positioned the project for a higher likelihood to succeed. The project would not have advanced had any one of the steps not been completed. The engagement of internal stakeholders in all aspects of the project was instrumental in the adoption of the proposed change. The true test will come when each community benefit leader prepares to complete the Community Health Needs Assessment for their hospital and the use of the standard tools and templates.

Implications of the project.

All staff impacted by the project must be trained on the new processes. To support that effort, a toolkit will be created in 2016 to serve as a resource for training of existing and new staff.

Conclusions

This project was instrumental in creating an organizational vision and strategic framework for impacting community health. What had been a function across 34 hospitals was reorganized in a manner that brought local efficiencies with minimal organizational disruption. Furthermore, there was organization-wide acknowledgement of the potential synergy and enhanced impact through the pursuit of an integrated approach to community health improvement.

The establishment of the Council offered a venue for the cross-divisional alignment of community health improvement strategies. This is the platform from which the organization can transform its community benefit functions that have been reactive to the needs of the community into one that is proactive in working in partnership with community leaders to create a shared vision for community health and introduce innovations that increase the community's capacity for health.

Finally, this project advanced the Mission of Providence Health & Services by optimizing community resources to care for those who are most vulnerable, especially those who are poor. Providence's vision statement calls for serving the community in partnership with others, *Together we answer the call of every person we serve: Know me, care for me, ease my way* (Providence Health & Services, 2014). By pursing community health improvement in partnership with organizational and community leaders, Providence exemplified the essential

characteristics of a population health approach for advancing community health and continued a legacy in care innovation established by the Sisters of Providence nearly 160 years ago.

Other Information

Funding

The funding of this project was provided by the Community Partnership division of Providence Health & Services. Incidental support activities, including finance and communication support, were rendered by internal resources performing their usual and customary duties.

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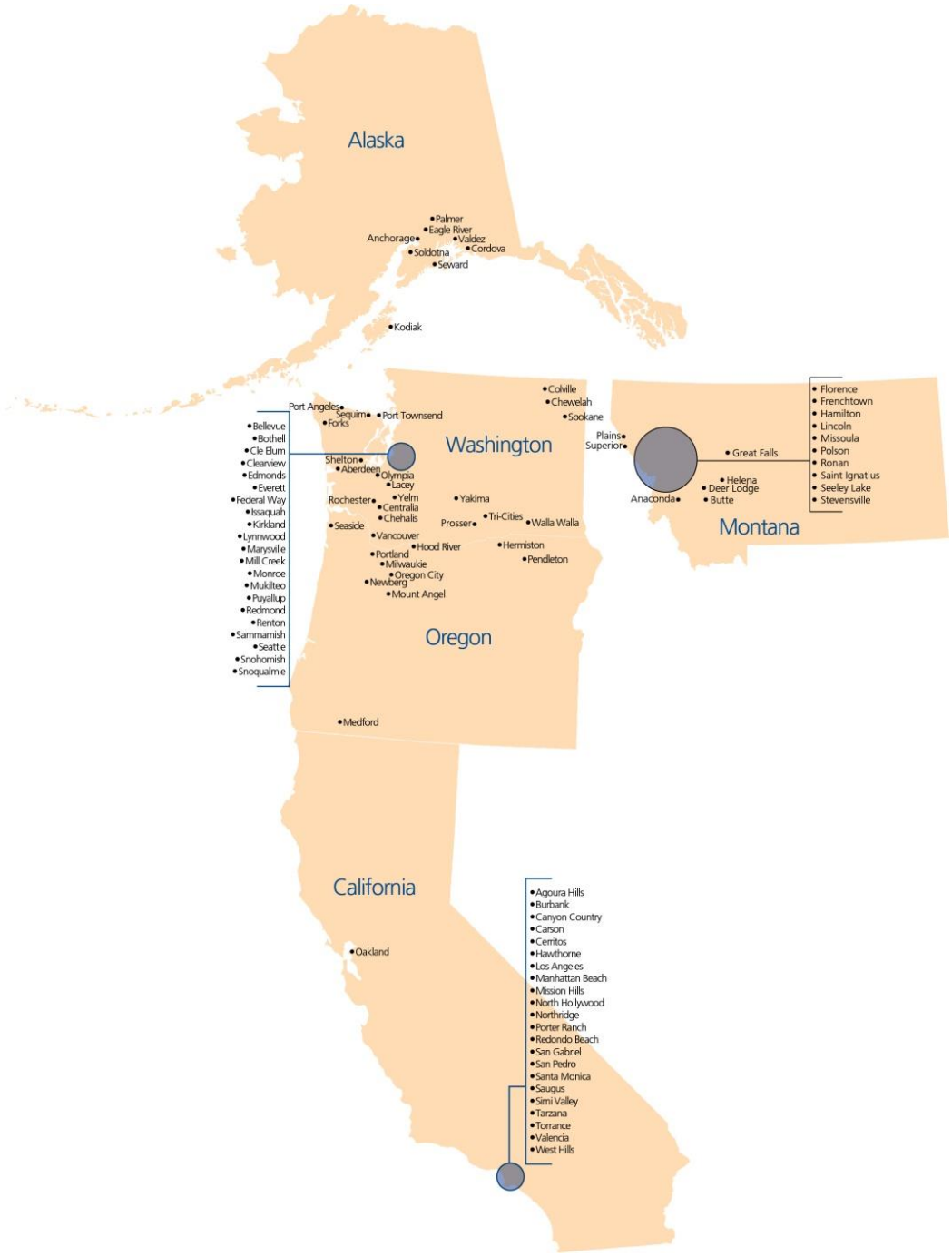
Appendices

Appendix A

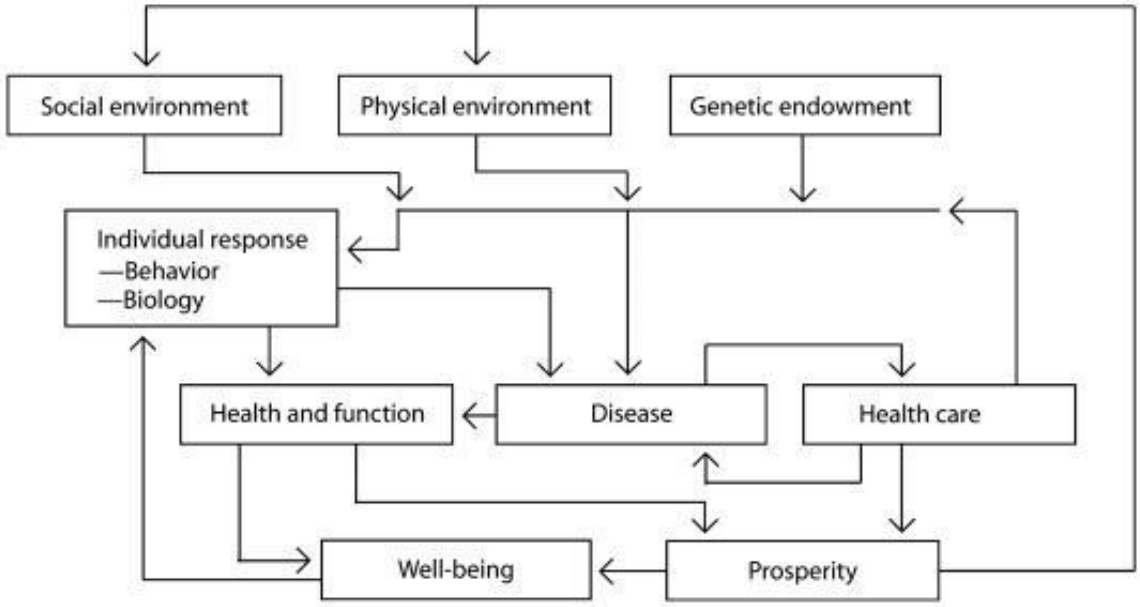
Providence Health & Services Locations



Appendix B

Population Health Models

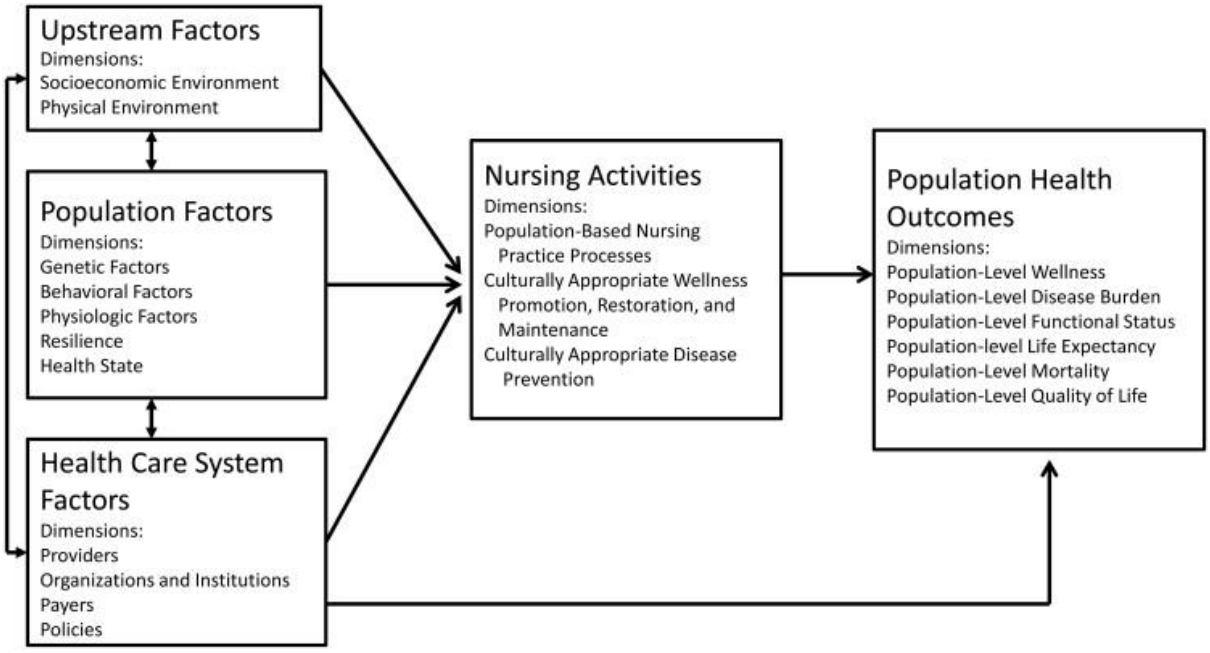
Model 1: Evan and Stoddart's Population Health Framework



Conceptual Framework for Patterns of Determinants of Health

Source: Reprinted with permission
Evan, R., and Stoddart, G. (2003) Consuming Research, Producing Policy? *Am J Public Health*. 93(3): 371–379.
PMCID: PMC1447746

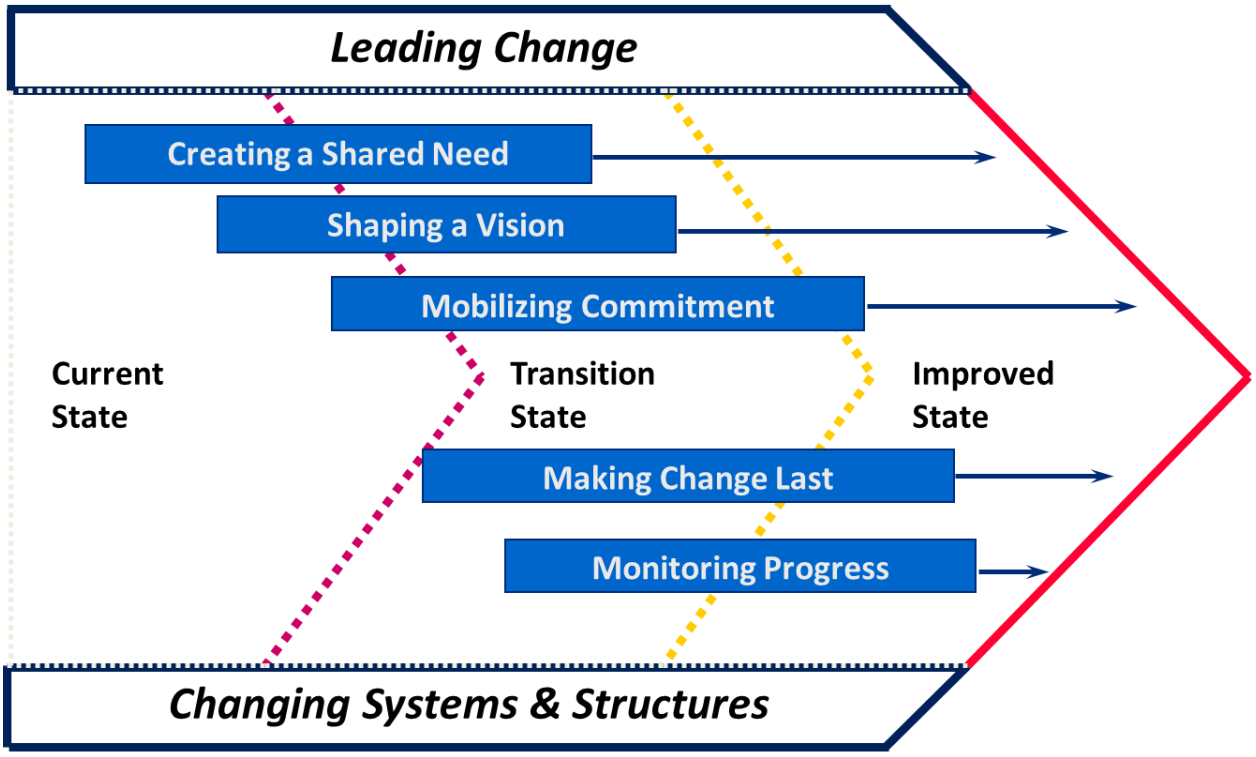
Model 2 – Fawcett and Ellenbecker's Conceptual Model of Nursing and Population Health



Source: Reprinted with permission 9/4/2015
Fawcett, J. and Ellenbecker, C. (2015) A Proposed Conceptual Model of Nursing and Population Health. Nursing Outlook, 63(3), 288-298. http://dx.doi.org/10.1016/j.outllk.2015.01.009.

Appendix C

Change Acceleration Model



Source: General Electric Company. (2003). Leadership Excellence in Healthcare: Change Acceleration Process Coaches Workshop. LDS Performance Solutions.

Appendix D

Project GANTT Chart

		11/2014	12/2014	1/2015	2/2015	3/2015	4/2015	5/2015	6/2015	7/2015	8/2015	9/2015
Leading Change / Creating a Shared Need												
Present a compelling reason for change	Present business case for a project and governance council to Senior Leadership Council (SLC)											
Ensure committed leadership	Appoint Executive Sponsor for project											
	Appoint project leader											
	Milestone: Senior Leadership Council approval for the project and designation of Executive Sponsor											
Shaping a Vision												
Establish a Community Investment and Development Council	Create Council charter											
	Select Council members											
	Secure approval of Council charter and membership by SLC											
	Orient Council members											
	Conduct Council meeting											
	Milestone: Community Investment and Development Council established											
Create a Community Investment Strategic Framework	Facilitated in-person work session to develop strategic framework concepts											
	Review of draft framework with internal stakeholders											
	Refinement of framework based on feedback from stakeholders											
	Milestone: Community Investment Strategic Framework developed											

		11/2014	12/2014	1/2015	2/2015	3/2015	4/2015	5/2015	6/2015	7/2015	8/2015	9/2015
Mobilizing Commitment												
Conduct audit of existing tools and processes	Conduct gap analysis of CHNAs against IRS regulations			■	■							
	Inventory all primary and secondary data sources			■	■							
	Inventory all identified community health needs			■	■							
Standardize CHNA processes and tools	Establish work groups						■					
	Identify work group leaders						■					
	Determine pre-work for work session						■					
	Conduct two-day in person work session							■				
	Conduct ongoing work group sessions virtually to vet and refine concepts							■	■			
	Present proposed templates to Council for discussion and approval								■			
	Milestone: CHNA process and templates approved for pilot testing								★			
	Test templates and process									■		
	Vet template format and ease of use									■	■	
	Finalize template for 2016 rollout										■	■
	Milestone: Standard CHNA process and templates developed											★
Centralize common data and reporting tools and templates	Establish work groups						■					
	Identify work group leaders						■					
	Determine pre-work for work session						■					
	Conduct two-day in person work session							■				
	Conduct ongoing work group sessions virtually to vet and refine concepts							■	■			

		11/2014	12/2014	1/2015	2/2015	3/2015	4/2015	5/2015	6/2015	7/2015	8/2015	9/2015
	Present standard data sources for centralization to Council for discussion and approval											
	Milestone: Standard data sources for centralization approved								★			
	Develop internal SharePoint site for posting tools and data sources											
	Milestone: SharePoint site developed											★
	Explore centralization of data analysis and functions through CORE											
Establish methodology to evaluate impact	Establish work groups											
	Identify work group leaders											
	Determine pre-work for work session											
	Conduct two-day in person work session											
	Conduct ongoing work group sessions virtually to vet and refine concepts											
	Present proposed methodology to measure impact to Council for discussion and approval											
	Milestone: Mental Health identified as a strategic priority for organization wide focus. Baseline to be established and impact measured annually								★			
Standardize reporting processes and tools	Establish work groups											
	Identify work group leaders											
	Determine pre-work for work session											
	Conduct day long in person work session											

		11/2014	12/2014	1/2015	2/2015	3/2015	4/2015	5/2015	6/2015	7/2015	8/2015	9/2015
	Conduct monthly in person or virtual meetings to develop processes that are accurate and compliant											
	Milestone: Financial reporting guidelines documented and disseminated for 2015 IRS reporting											
Making Change Last												
Create visual reminders of the change	All tools and templates are posted on the SharePoint site											
Celebrate the change agents	All Council members are acknowledged and recognized for their contributions											
Monitoring Progress												
Establish accountability for the success of the project	Conduct bi-weekly meetings with project Executive Sponsor											
	Submit quarterly status reports to leadership and board members											

Appendix E

Project Pro Forma

Option 1 Return of Investment Calculations, ROI = $0 / $13,900 = $0

Project Implementation and Operational Costs							
	Planning and Start-up period			Operational period			
Category of costs	Planning Q1-2 2015	Training	Start-up Q3-4 2015	Year 1	Year 2	Year 3	Total Costs
Personnel (1)	$ 204,984	$ -	$ -	$ -	$ -	$ -	$ 204,984
In-person meetings (2)	$ 78,200	$ -	$ -	$ -	$ -	$ -	$ 78,200
Virtual meetings and email (3)	$ 30,375	$ -	$ -	$ -	$ -	$ -	$ 30,375
Supplies (4)	$ 500	$ -	$ -	$ -	$ -	$ -	$ 500
Data fees (5)	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Training (6)	$ -	$ -	$ -	$ -	$ -	$ -	$ -
IS and data management (7)	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Analytics (8)	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Outreach and communication (9)	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total	$ 314,059	$ -	$ -	$ -	$ -	$ -	$ 314,059
less salaries and benefits in existing budgets	$ 300,159	$ -	$ -	$ -	$ -	$ -	$ 300,159
Total	$ 13,900	$ -	$ -	$ -	$ -	$ -	$ 13,900

Project Net Returns					
		Comparison period (Y1 - Y3)	Implementation period (Y1 - Y3)	Net Change	
Changes in Revenue		$ -	$ -	$ -	
Changes in Cost	Personnel (10)	$ 1,844,340	$ 1,844,340		
	Consultant (11)	$ 123,636	$ 123,636	$ -	
	Analysis(8, 12)	$ 92,727	$ 92,727	$ -	
	Communication (9, 13)	$ 781,132	$ 781,132	$ -	
	Compliance (14)	$ -	$ -	$ -	

Option 2 Return of Investment Calculations, ROI = $621,520 / $167,680 = 3.71

Project Implementation and Operational Costs							
	Planning and Start-up period			Operational period			
Category of costs	Planning Q1-2 2015	Training	Start-up Q3-4 2015	Year 1	Year 2	Year 3	Total Costs
Personnel (1)	$ 204,984	$ 1,093	$204,984	$103,896	$107,013	$110,223	$ 732,193
In-person meetings (2)	$ 78,200	$ -	$ 39,100	$ 78,200	$ 80,546	$ 82,962	$ 359,008
Virtual meetings and email (3)	$ 30,375	$ -	$ 12,150	$ 24,300	$ 25,029	$ 25,780	$ 117,634
Supplies (4)	$ 500	$ -	$ 2,000	$ 2,000	$ 2,000	$ 2,000	$ 8,500
Data fees (5)	$ -	$ -	$ -	$ -	$ 10,000	$ 10,000	$ 20,000
Training (6)	$ -	$16,580	$ -	$ 8,100	$ 8,343	$ 8,593	$ 41,616
IS and data management (7)	$ -	$ -	$ 10,400	$ 14,000	$ 14,420	$ 14,853	$ 53,673
Analytics (8)	$ -	$ -	$ 16,200	$ 32,400	$ 33,372	$ 34,373	$ 116,345
Outreach and communication (9)	$ -	$ -	$ 47,120	$ 89,240	$ 91,917	$ 94,675	$ 322,952
Total	$ 314,059	$17,673	$331,954	$352,136	$372,640	$383,459	$1,771,921
less salaries and benefits in existing operating budgets	$ 300,159	$15,552	$312,854	$315,661	$325,131	$334,885	$1,604,242
Total	$ 13,900	$ 2,121	$ 19,100	$ 36,475	$ 47,509	$ 48,575	$ 167,680

Project Net Returns					
		Comparison period (Y1 - Y3)	Implementation period (Y1 - Y3)	Net Change	
Changes in Revenue		$ -	$ -	$ -	
Changes in Cost	Personnel (10)	$ 1,844,340	$ 1,844,340	$ -	
	Consultant (11)	$ 123,636	$ -	$ (123,636)	
	Analysis(8, 12)	$ 92,727	$ 100,143	$ 7,416	Enhanced quality
	Communication (9, 13)	$ 781,132	$ 275,832	$ (505,300)	Enhanced quality
	Compliance (14)	$ -	$ -	$ -	Protected tax status
				$ (621,520)	

Option 3 Return of Investment Calculations, ROI = $1,272,646 /$ 1,098,441 = 1.16

Project Implementation and Operational Costs							
	Planning and Start-up period			Operational period			
Category of costs	Planning Q1-2 2015	Training	Start-up Q3-4 2015	Year 1	Year 2	Year 3	Total Costs
Personnel (1)	$204,984	$ 1,093	$ 661,284	$1,016,496	$1,046,991	$1,078,401	$4,009,248
In-person meetings (2)	$ 78,200	$ -	$ 39,100	$ 78,200	$ 80,546	$ 82,962	$ 359,008
Virtual meetings and email (3)	$ 30,375	$ -	$ 12,150	$ 24,300	$ 25,029	$ 25,780	$ 117,634
Supplies (4)	$ 500	$ -	$ 2,000	$ 2,000	$ 2,000	$ 2,000	$ 8,500
Data fees (5)	$ -	$ -	$ -	$ -	$ 10,000	$ 10,000	$ 20,000
Training (6)	$ -	$16,580	$ -	$ 8,100	$ 8,343	$ 8,593	$ 41,616
IS and data mgt (7)	$ -	$ -	$ 10,400	$ 14,000	$ 14,420	$ 14,853	$ 53,673
Analytics (8)	$ -	$ -	$ 16,200	$ 32,400	$ 33,372	$ 34,373	$ 116,345
Outreach and communication (9)	$ -	$ -	$ 47,120	$ 89,240	$ 91,917	$ 94,675	$ 322,952
Total	$314,059	$17,673	$ 788,254	$1,264,736	$1,312,618	$1,351,637	$5,048,977
less salary/ ben in existing **corporate** budgets	$300,159	$15,552	$ 323,654	$ 337,261	$ 347,379	$ 357,800	$1,681,805
less salary/bens in existing **regional** budgets	$ -	$ -	$ 315,900	$ 631,800	$ 650,754	$ 670,277	$2,268,731
Total	$ 13,900	$ 2,121	$ 148,700	$ 295,675	$ 314,485	$ 323,560	$1,098,441

Project Net Returns					
		Comparison period (Y1 - Y3)	Implementation period (Y1 - Y3)	Net Change	
Changes in Revenue		$ -	$ -	$ -	
Changes in Cost	Personnel (10)	$ 1,844,340	$ 1,193,396	$ (650,944)	New executive leader
	Consultant (11)	$ 123,636	$ -	$ (123,636)	
	Analysis(8, 12)	$ 92,727	$ 100,143	$ 7,416	Enhanced quality
	Communication (9, 13)	$ 781,132	$ 275,832	$ (505,300)	Enhanced quality
	Compliance (14)	$ -	$ -	$ -	Protected tax status
				$ (1,272,464)	

Project Pro Forma Assumptions

Note	Category	Phase	Type of Expense	Calculation	Amount
1	Personnel	Planning	Executive Sponsor	208 hours x $250/hr + 35% benefits	$70,200
			Project Manager	1040 hours x $90/hr + 35% benefits	$126,360
			Admin Assistant	208 hours x $30/hr + 35% benefits	$8,424
		Training	Project Manager	9 hours x $90/hr +35% benefits	$1,093
		Start-up	Executive Sponsor	208 hours x $250/hr + 35% benefits	$70,200
			Project Manager	1040 hours x $90/hr + 35% benefits	$126,360
			Admin Assistant	208 hours x $30/hr + 35% benefits	$8,424
			Community benefit staff	1040 hrs x $75/hr +35% benefits x 3	$315,900
			Community benefit executive	1040 hrs x $100/hr+ 35% benefits	$140,400
		Year 1	Executive Sponsor	208 hours x $250/hr + 35% benefits	$70,200
			Project Manager	$90/hr + 35% benefits	$25,272
			Admin Assistant	208 hours x $30/hr + 35% benefits	$8,424
			Community benefit staff	2080 hrs x $75/hr +35% benefits x 3	$631,800
			Community benefit executive	2080 hrs x $100/hr+ 35% benefits	$280,800
		Year 2 and Year 3	Personnel salaries/benefits	adjusted by 3% for inflation	
2	In-person meetings	Planning - 2 In-person sessions	Council members	16 hours x$75/hr + 35% benefits x 20	$32,400
			Food	$110 / person / meeting x 20	$2,200
			Travel / lodging	$300 / person / meeting x 15	$4,500
		Start-up - 1 In-person session	Council members	16 hours x$75/hr + 35% benefits x 20	$32,400
			Food	$110 / person / meeting x 20	$2,200
			Travel / lodging	$300 / person / meeting x 15	$4,500
		Year 1 - 2 In-person sessions	Council members	16 hours x$75/hr + 35% benefits x 20	$32,400
			Food	$110 / person / meeting x 20	$2,200
			Travel / lodging	$300 / person / meeting x 15	$4,500

Note	Category	Phase	Type of Expense	Calculation	Amount
		Year 2 and Year 3	Personnel salaries/benefits	adjusted by 3% for inflation	
3	Virtual meetings and email	Planning	Council members	15 hours x$75/hr+35% benefits x20	$30,375
		Start-up	Council members	6 hours x$75+35% benefits x 20	$12,150
		Year 1	Council members	6 hours x$75+35% benefits x 20	$12,150
		Year 2 and Year 3	Personnel salaries/benefits	adjusted by 3% for inflation	
4	Supplies	Planning	General meeting supplies		$500
		Start-up and Years 1- 3	General meeting supplies		$2000
5	Data fees	Year 2 and Year 3	Proprietary data sets for advanced analysis		$10,000
6	Training	Training	Curriculum development	40 hrs x $60/hr + 35% benefits	$3,240
			Material development	40 hrs x $60/hr + 35% benefits	$3,240
			Printing		$2,000
			Train the trainer	4 hrs x $75/hr+35% benefits x 20	$8,100
		Year 1	Ongoing training -new staff	4 hrs x $75/hr+35% benefits x 20	$8,100
		Year 2 and Year 3	Personnel salaries/benefits	adjusted by 3% for inflation	
7	Information Systems and Data Management	Start-up	Software license	$500 / license x 20 = $10,000 / 2 for 6 months	$5,000
			Data table programming	40 hrs x $100/hr + 35% benefits	$5,400
		Years 1- 3	Annual software license fee		$10,000
			Data maintenance	3% adjustment for inflation Y2 and Y3	$4,000
8	Analytics	Start-up	Analytic support	40 hrs / $100/hr + 35% benefit x 5 hosp	$27,000
		Years 1- 3	Analytic support	40 hrs / $100/hr + 35% benefit x 10 hosp	$54,000
		Year 2 and Year 3		adjusted by 3% for inflation	
9	Communications	Start-up	Communication personnel	520 hrs / $60/hr + 35% benefits	$42,120
			Material production		$5,000
		Years 1	Communication personnel	1040 hrs / $60/hr+35% benefits = $84,240	$84,240
			Material production		$5,000
		Year 2 and Year 3		adjusted by 3% for inflation	

Note	Category	Phase	Type of Expense	Calculation	Amount
10	Personnel	Years 1- 3	Community benefit staff	1040 hrs x 17 reports x $75/hr+35% benefits	$1,844,340
				3% adjustment for inflation Y2 and Y3	
11	Consultant	Years 1- 3	Contracted assessments	$20,000 per assessment x 2/yr x 3 yrs	$123,636
				3% adjustment for inflation Y2 and Y3	
12	Analytic support	Years 1- 3	Contracted analysis	$10,000 per assessment x 3/yr x 3 yrs	$92,727
				3% adjustment for inflation Y2 and Y3	
13	Communication support	Years 1- 3	Report writing	520 hrs x $60/hr x 6 reports/year	$781,132
				3% adjustment for inflation Y2 and Y3	

Appendix F

Project Messaging Plan

Messaging Plan					
Audience	**Findings of internal assessment**	**Communication strategy**	**Key message**	**Communication methodology**	**Evaluation of effectiveness of communication**
Chief Executives from each state	1. The executives value efficiency and compliance. 2. The executives are agreeable to allocate funds for initiatives if supported by a comprehensive business case.	1. Reinforce the value of the project and highlight opportunity to increase community benefit reach and impact 2. Inform executives of how the project will achieve heightened efficiency and compliance 3. Seek approval for project 4. Seek authorization for required human and financial resources	1. Effective execution of the project is a core Community Partnerships strategy and will increase community benefit reach and impact 2. Through expert to expert collaboration, identified opportunities to centralize and/or standardize processes will increase efficiency 3. In partnership with finance, standard policies and procedures will be developed and implemented system-wide to ensure compliance with IRS requirements 4. The project was developed by community benefit experts system-wide and has their full support	1. A fact sheet summarizing the business case for centralization / standardization of data management and reporting developed 2. Fact sheet to be discussed at in-person monthly Leadership Council 3. Project message map to be projected on screen during discussion 4. A representative from the Community Investment Council to participate in the discussion and clarify questions	1. Members of the Leadership Council express consensus for the project 2. Members of the Leadership Council authorize required human and financial resources to implement project – OR – indicate process for securing resources.
Chief Executives from each state	1. Select executives perceive that centralizing services will result in a loss of control locally and may resist the project.	1. To gain consensus for the project, community benefit leaders will meet with their executive prior to the SLC meeting to socialize the project, express their support for the approach and	1. The proposed project was developed by the community benefit leader group and local representatives had a voice in the design	1. Community benefit leaders will meet in-person with the local chief executive	1. Executives are knowledgeable of project prior to the Leadership Council presentation 2. Executives articulate areas of concern and their level of support or resistance

Messaging Plan					
Audience	**Findings of internal assessment**	**Communication strategy**	**Key message**	**Communication methodology**	**Evaluation of effectiveness of communication**
		why, identify areas of concern, and clarify questions 2. Responses to identified areas of concern are developed	2. The project will result in higher efficiency and compliance at the local level 3. The local executive has final authority for deciding if their organization will participate		
Community benefit leaders	1. Select community benefit leaders express a personal lack of competence and / or resources for data collection, analysis and reporting 2. There is consensus among community benefit leaders for a centralize data collection and storage process.	1. Reinforce the value of the project and highlight opportunity to increase community benefit reach and impact 2. Articulate benefits of a centralized / standardized data collection, analysis and reporting process 3. Reinforce the value of the project and highlight opportunities for enhanced information, access to data, and local efficiencies.	1. Effective execution of the project is a core Community Partnerships strategy and will increase reach and impact 2. Community benefit leaders have a voice in the design of centralized and standardized processes 3. Centralized structures can meet the local need and optimize available resources 4. Shared expertise allows for enhanced quality		1. Leaders express support for the project and engagement in the implementation of the action steps
	1. The majority of community benefit leaders are concerned about compliance with the new IRS regulations for reporting 2. There is consensus among community benefit leaders to standardize IRS reporting processes and templates.	1. Articulate how a standardized data collection and reporting process based on best practices will increase accuracy and ensure compliance 2. Reinforce the value of the project and highlight opportunities for enhanced information, access to data, and local efficiencies	1. Community benefit leaders have a voice in the design of centralized and standardized processes 2. Standardized processes can meet the local need and also ensure compliance 3. Shared expertise allows for enhanced capacity and quality at the local level	1. IRS requirements and contact information for designated expert posted on project website	1. Expressed confidence that compliance will be achieved and engagement in the implementation of the action steps

Messaging Plan					
Audience	**Findings of internal assessment**	**Communication strategy**	**Key message**	**Communication methodology**	**Evaluation of effectiveness of communication**
Risk and compliance managers	1. Risk and compliance managers are concerned about compliance with new IRS regulations for community benefit reporting.	1. Reinforce the value of the project and highlight opportunity to increase community benefit reach and impact 2. Articulate how a standardized data collection and reporting process based on best practices will increase accuracy and ensure compliance	1. Effective execution of the project is a core Community Partnerships strategy and will increase community benefit reach and impact 2. Risk and compliance leaders have a voice in the design of centralized and standardized processes related to IRS reporting 3. Standardized process can meet the local need and also ensure compliance	1. Participate in the development of revised policies and procedures to reflect new workflows and processes 2. Delineate IRS requirements and contact information for designated expert for posting on common website	1. Expressed support for the project and engagement in the implementation of the action steps
Finance directors	1. Finance leaders are concerned about compliance with new IRS regulations for community benefit reporting. 2. Finance leaders are concerned about the accuracy and consistency of community benefit reporting at the local market level.	1. Reinforce the value of the project and highlight opportunity to increase community benefit reach and impact 2. Articulate how a standardized data collection and reporting process based on best practices will increase accuracy and ensure compliance	1. Effective execution of the project is a core Community Partnerships strategy and will increase community benefit reach and impact 2. Risk and compliance leaders have a voice in the design of centralized and standardized processes related to IRS reporting 3. Standardized process can meet the local need and also ensure compliance	1. Participate in the development of revised policies and procedures to reflect new workflows and processes	1. Expressed support for the project and engagement in the implementation of the action steps
Health intelligence and data analysts	1. Health intelligence and clinical data analysts are willing to partner with	1. Reinforce the value of the project and highlight opportunity to increase	1. Effective execution of the project is a core Community Partnerships strategy and will		1. Expressed support for the project and engagement in the implementation

Messaging Plan					
Audience	**Findings of internal assessment**	**Communication strategy**	**Key message**	**Communication methodology**	**Evaluation of effectiveness of communication**
	community benefit and finance leaders to create enhanced processes for data management and analysis.	community benefit reach and impact	increase community benefit reach and impact		of the action steps

Appendix G

Council Charter

Community Investment and Development Governance Council 2015 Charter

MISSION
As people of Providence, we reveal God's love for all, especially the poor and vulnerable, through our compassionate service.

VISION
Together, we answer the call of every person we serve: Know me, care for me, ease my way. ®

CORE SYSTEM STRATEGY
Creating healthier communities, together: We work together across our five states, and with partners who share our values, to improve the health and well-being of everyone in our communities.
Inspire and develop our people | Build enduring relationships with consumers | Create alignment with clinicians & care teams | Develop and thrive under new care delivery & economic models | Grow by optimizing expert to expert capabilities

Role: The Council provides strategic direction, planning and oversight to advance Providence's Community Investment and Development (CI&D) program. The Council will identify and articulate the system-wide strategies, resources, systems and structures that align community benefit and investment activities (including reporting) with our core strategy of *Creating Healthier Communities, Together.* The council will develop a common strategic framework for CI&D activities, as well as performance measures that align with community health improvement. The Council will also support the effective communication of Providence's community benefit activity in a manner that addresses public expectations and reflects the continued Mission of Providence.

Sponsoring Group/Organization: Leadership Council

Members:

Name	Title	Role on the Council
Joel Gilbertson	SVP Com Partnership/Ext Affair	Executive Sponsor (Interim Owner/Chair)
Vacant	Chief Community Invest Officer	Owner/Chair
Debbie Burton, RN	SVP Chief Nursing Officer	Member
Craig Wright, MD	Chief Medical Officer-PMG	Member
Sara Clements-Sampson	Community Benefit Coordinator (PHC)	Member
Allison Fong	Regional Manager Strategic Planning (AK)	Member
Tom Gibbon	Manager Comm Specialty Clinic (SHS)	Member
Sandy Gregg	Sr Dir Comm Partnerships Intgr	Member
Merry Hutton	Regional Manager Amb Beh Hlth Comm Ben (WMT)	Member
Pam Mariea-Nason	Exec-Community Health Div (OR)	Member
TBD	Accountable Care Services	Member
Jack Mudd	SVP Mission Leadership	Member
Deanne Okazaki	Strategic Services Manager (NWR)	Member
Dan Harris	VP Finance Operations	Member
Kathie Oreb	Director of Mission Services (SER)	Member
Ron Sorensen	Sr Dir Community Partnerships (CA)	Member

John Vassall, MD	Chief Medical Officer, SHS	Member
Colleen Wadden	External Communications	Member
Angie Wolle	VP Mission SW, (SWR)	Member
Gina Mendoza	Project Manager Strategic Ops	Staff

Ongoing Functions:

1. Responsible for advancing Providence's community investment & development work with a focus on:
    a. Developing CI&D strategic plan and performance measures (with a focus on community health improvement), including system dashboard measures
    b. Defining cross regional and functional collaboration opportunities
    c. Identifying resourcing needs
    d. Developing consistent approach to needs assessment and benefit planning
    e. Ensuring consistency and efficiency in financial reporting
    f. Providing governance to collaborative initiatives identified by this council
    g. Facilitating expert-to-expert collaboration and knowledge sharing across all regions and functions
    h. Coordinate communications effort including: internal/external reporting requirements; ongoing communication about Community Benefit efforts in the communities we serve; and linkage to Community Partnerships around community investment programs

2. Responsible for oversight of technical and development groups

Out of scope:

1. Directing and managing regional Community Benefit programs
2. Technical work such as financial and tax reporting, regulatory, risk and compliance

Objectives and Measurement:

2015 Objectives	Measurement	Support Needed
Develop strategic framework for community investment planning	TBD	
Develop community health index in collaboration with clinical program services	TBD	Clinical program services partners

Decision Making Linkage(s):
Healthcare Operations Council
Clinical Council

Interaction with Regional and Shared Services Customers:
Local Community Benefit / Health teams
Non-Chartered Sub-Groups:

Sub-Group	Role	2015 Objectives	Owner
• CI&D Technical Support Council (Finance & Reporting, Tax, Risk & Compliance, etc.)		TBD	TBD

Meeting Frequency: This group will meet at least quarterly, work groups more often to execute tactics

Sunset: December 2015

Appendix H

Strategic Framework

	Community Investment and Development				
Community Partnership Strategic Pillars	Deepen connection of caregivers to community programs	Build enduring community relationships	Elevate local and national understanding of Providence	Leverage assets and investments to build healthier communities	Secure sustainable resources to support core strategy

Priorities	• Support planning and development of system-wide volunteer program
	• Identify community partners / opportunities for caregiver volunteerism
	• Strengthen caregiver understanding of community benefit program and investments
	• Inspire caregivers and increase engagement through stories of impact and advancement of Mission
	• Evaluate opportunities for alignment with leadership and caregiver formation programs
		• Define best-practice for ongoing communication to community partners around community investment efforts
		• Develop structure to report number of people served for community investments
		• Develop structure to track volunteer hours by community partner
			• Develop aggregate impact and unique stories of community investment work for use by advocacy and communications teams
			• Incorporate community investment work and partners into policy and advocacy planning at state and federal level
			• Develop outreach plan for highlighting community investment program with national associations and events
			• Establish routine communication with internal, local, state and national audiences
				• Establish uniform approach to community investment program activity, including:
				  • Definitions and minimum specs;
				  • Needs assessment and health improvement plans; and,
				  • Data collection, storage, analysis and report generation
				• Establish technical support council to support efficient process for tracking and reporting community benefit and E2E sharing
				• Develop community health index in collaboration with clinical council
					• Develop market and system level approach to expand corporate and third-party partnerships and leverage community investments
					• Evaluate system grants / research program in partnership with clinical council

Proposed Metrics	Reach: number of unique individuals served; community investment dollars leveraged; caregiver volunteer hours Social Accountability: CB as a multiple tax preference received and benchmark against peers Efficiency: Total cost per uninsured or Medicaid individual and a standard health index				

Appendix I

Community Investment and Development SharePoint Site

PROVIDENCE Health & Services

Community Investment and Development ▸ Home

I Like It | Tags & Notes

All Sites

Libraries

PH&S Details: Organizational principles and communication

Needs Assessment: Planning and analysis

Health Improvement: Prioritization, partnerships and implementation

Internal Tracking: CIBSA and stakeholder dashboards

Regulatory Resources: Federal and state reporting

Lists

Calendar

Tasks

Discussions

Team Discussion

Recycle Bin

All Site Content

Community Investment & Development:

Resources to support ministry community benefit strategies

PH&S Details: Organizational principles and communication

Type	Name
	Mission and core values
	Communication templates and examples
	Ministry overview

Add document

Needs Assessment: Planning and analysis

Type	Name
	Population data
	Survey templates and resources
	Analysis and reporting

Add document

Health Improvement: Prioritization, partnerships and implementation

Type	Name
	Prioritization of community need
	Community partners
	CHIP templates

Add document

Internal Tracking: CIBSA and stakeholder dashboards

Type	Name
	CIBSA - user reference materials
	Templates and dashboards

Add document

Regulatory Resources: Federal and state reporting

Type	Name
	State specific resources
	Federal resources and reporting templates

Add document

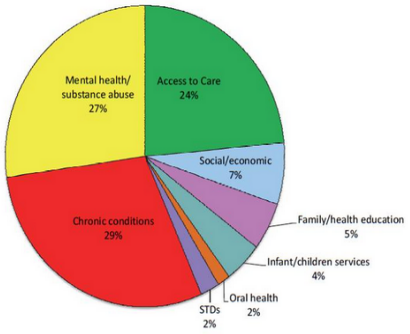
2014 community benefit information is available on the Providence cares website.

PROVIDENCE CARES

Creating healthier communities, together

Alaska	Anchorage, Alaska Medical Center
	Kodiak Island, Medical Center
	Valdez, Medical Center
Montana	Polson, St. Joseph Medical Center
	Missoula, St. Patrick Hospital
California	Burbank, St. Joseph Medical Center
	Mission Hills, Holy Cross Medical Center
	Tarzana, Medical Center
	Valley Care, PSJMC, PHCMC and PTMC
	Torrance, Little Company of Mary
	San Pedro, Little Company of Mary
Oregon	Portland, Medical Center
	Portland, St. Vincent Medical Center
	Milwaukie, Hospital
	Oregon City, Willamette Falls Medical Center
	Hood River, Memorial Hospital
	Newberg, Hospital
	Seaside, Hospital
	Medford, Medical Center
Washington	Seattle, Swedish First Hill
	Seattle, Swedish Cherry Hill
	Seattle, Swedish Ballard
	Issaquah, Swedish Issaquah
	Edmonds, Swedish Edmonds
	Everett, Regional Medical Center
	Olympia, St. Peter Hospital
	Centralia, Hospital
	Spokane, Sacred Heart
	Spokane, Holy Family Hospital
	Colville, Mount Carmel Hospital
	Chewelah, St. Josephs Hospital
	Walla Walla, St. Mary Medical Center

CHNA: 2014 common themes system wide



Appendix J

Project Gap Analysis

	Current State	Desired Future State	Intervention
Accountability for community investments	Regional Chief Executive	Regional Chief Executive	No change
Oversight of community benefit function	Decentralized process – Varying collaboration between and among 34 acute care facilities Lack of a formal venue for networking and/or collaborating across facilities or communities	Formal venue that promotes collaboration across 34 acute care facilities to spread and adopt best practices, decrease redundancy, and share resources	Establish Community Investment Governance Council
Strategic alignment of community investment functions	Decentralized process – strategic vision and priorities determine and resourced at the acute facility level Diverse structures and processes for the allocation of resources within each community	Organization-wide strategic vision for community investment to guide initiatives and resource allocation	Create community investment strategic framework
Community Health Needs Assessment	Decentralized process – planned and conducted at the hospital level Varying support, resources, and internal competency; some facilities outsource	Uniform process and tools for conduction of assessments organization-wide	Delineate standard CHNA process Create standard CHNA templates for report writing
Implementation planning	Decentralized process – planned and conducted at the hospital level Varying support, resources, and internal competency	Uniform guidelines for the selection of health priorities for community investment Organization-wide collaboration on community health initiative	Established principles for decision making

	Current State	Desired Future State	Intervention
Data collection and analysis	Decentralized process – planned and conducted at the hospital level Varying support, resources, and internal competency; some facilities outsource	Uniform process and tools for data collection and analysis	Establish guidelines for data collection and analysis Centralized common data sources Designate data analysis resources
Reporting	Decentralized process – planned and conducted at the hospital level Varying support, resources, and internal competency; some facilities outsource	Uniform, accurate and efficient reporting process that is compliant with all IRS requirements	Establish guidelines for reporting
Compliance	All facilities compliant with 2010 IRS requirements	All facilities compliant with 2014 IRS requirements	Conduct an internal audit of CHNA and reporting processes
Evaluation of impact	Public reporting of annual community benefit expenses Limited information about total number of individuals touched	Measurable impact of community investment expressed in improvements in health status Maintain consistent level of community investment, yet increase number of individuals touched and community health status	Develop community investment metric and / index

Appendix K

Project SWOT Analysis

Strengths	Weaknesses
▪ Providence's commitment to creating healthier communities and a long term community investment strategy ▪ Community Benefit leadership support and willingness to collaborate across the organization ▪ Internal expertise and resources for data collection, management and analysis ▪ Executive leadership support to standardize and/or centralize workflows ▪ Organizational structure for the strategic alignment of community benefit, philanthropy and advocacy agendas	▪ Inconsistent process and templates for data collection, management, analysis and reporting, thus unable to track trends or compare data across the organization ▪ Insufficient or conflicting data on the health status of the community ▪ Local community benefit, operations and/or finance leaders may resist changes in existing processes and accountability ▪ Community partners / organizations may have aligned priorities, however, no one entity has authority for directing global initiatives and resources
Opportunities	**Threats**
▪ Improved information for Health Improvement Planning ▪ Common measurement of community health impact ▪ Optimizing community health investments ▪ IRS compliance ▪ Elevated awareness of Providence's commitment to community health improvement	▪ New IRS regulations for the conduction and reporting of Community Health Needs Assessments and Health Improvement Plans

Appendix L

Evidence Table

No	Author and Date	Evidence Type	Sample, Sample Size and Setting	Study Purpose	Study Findings	Evidence Level and Quality
1	Bigbee, J. L. & Issel, M. (2012)	Systematic review	Reviewed twelve conceptual public health nursing models that exemplified practice theories Models were identified via searching CINAHL, public health nursing texts, and select books	To identify a relevant theory-based approach to guide population-focused public health nursing practice	Identified twelve theory based public health nursing models and assessed them in terms of nursing practice, public health practice and competencies, and applicability to nursing practice. Effectiveness of each model on impacting the determinants of health was not well documented Authors acknowledge that further refinement and or consolidation of models would be required to meet the today's community health needs	4B
2	Coburn, D., Denny, K., Mykhalovskiy, E., McDonough, P., Robertson, A., Love, R., (2003)	Expert Opinion	Not applicable	To critique Canadian population health models	Critiqued Evan and Stoddart's model and found the strengths to be the linkage of economics, society, and health Limitations of the model were: too simplistic, presented the macro level view when health is driven at the micro level; and did not define the role of policy makers in socioeconomic disparities	5A
3	Cohen, D., Huynh, T., Sebold, A., Harvey, J., Neudorf, C., & Brown, A. (2014)	Qualitative study	Interviewed twenty-one Canadian population health leaders	To document how perspectives on population health principles were into planning and decision-making by Canadian population health leaders	Convergence of opinion on six elements of population health definition; divergent opinions on how the approach is operationalized Variances of operationalizing population health attributed to population served, and human and financial resources for interventions	3B
4	Dunn, J. R. (2006)	Expert opinion	Not applicable	To delineate the elements of a population health framework	Delineated the elements of population health as: as broad and complex and requires an explanation of the differential distribution of health by socioeconomic position	5A

No	Author and Date	Evidence Type	Sample, Sample Size and Setting	Study Purpose	Study Findings	Evidence Level and Quality
5	Evans, R. and Stoddart, G. (2003)	Expert opinion	Not applicable	To critique the population health framework they developed in 1990	Concluded that their original concept presented relevant factors for influencing health however, the model did not portray the complexity of the interaction between the factors nor did it illustrate the relative impact of each factor	5A
6	Friedman, D. and Starfield, B. (2003)	Meta-synthesis	Reviewed the conceptual frameworks of six population health thought leaders	To conduct a narrative evaluation of the way population health is defined and operationalized by industry thought leaders	Illustrated the inconsistency in a common definition and model for population health Discussed causes for inconsistency in health outcomes among communities that have a population health approach Valuable delineation of the various population health models in the literature	3B
7	Glouberman, S., Millar, J.	Expert opinion	Not applicable	To present the evolution of determinants of health concepts in the Canadian health system	Thomas McKeown gave life to the framework for a population health approach for health improvement by connecting two disparate approaches – health promotion programs and health research	5A
8	Kickbusch, I. (2003)	Expert opinion	Not applicable	To present the development of European health practices based on 1980s World Health Organization policies	The WHO Health for All program provided a framework for the Ottawa Charter for Health Promotion The documents reframe health policy priorities from a risk factor approach to strategies that address determinants of health The 1970s European social policies provided the foundation for a social health model in the 1980s	5A
9	Kindig, D. A. (2007)	Expert opinion	Not applicable	To define the concept of population health and delineate the elements of a population health framework	Delineated the elements of population health as: Population and health; population health outcomes; determinants of health outcomes; and policies and interventions	5A

No	Author and Date	Evidence Type	Sample, Sample Size and Setting	Study Purpose	Study Findings	Evidence Level and Quality
10	Kindig, D., & Stoddart, G. (2003)	Literature review	Reviewed the population health definitions of seven population health thought leaders	To define the concept of population health and delineate the elements of a population health framework	Presented an inventory of various definitions of population health Delineated the elements of population health as: the interconnectedness of health outcomes and distribution in a population (dependent variables), patterns of health determinants over the life course (independent variables), and policies and interventions at the individual and social levels	5A
11	MacDonald, S. E., Newburn-Cook, C. V., Allen, M., & Reutter, L. (2012).	Literature review	Not applicable	To define the population health framework and its relevance for nursing practice and research	Population health is based on the various health related entities working in partnership Without clear authority it is difficult to demand cooperation among community partners Nurses have been trained in nurse-patient relationships and transitioning to nurse-population perspectives is a significant shift in perspective Authors provided a list of seminal articles and manuscripts in the evolution of the population health framework Authors highlight relevant nursing theories that are aligned with population health models	5A
12	Public Health Agency of Canada. (2014)	Expert opinion	Not applicable	To define the concept of population health and delineate the elements of a population health framework	Delineated the elements of population health as: Focus on the health of populations; address the determinants of health and their interactions; base decision on evidence; increase upstream investments; apply multiple interventions and strategies; collaborate across sectors and levels; employ mechanisms for public involvement; and, demonstrate accountability for health outcomes	5A

No	Author and Date	Evidence Type	Sample, Sample Size and Setting	Study Purpose	Study Findings	Evidence Level and Quality
13	Stoto, M. A. (2013)	Expert opinion	Not applicable	To explore the potential for a population health approach to achieve the U.S. health reform goals	An expansion of knowledge in population health will advance U.S. health reform goals	5A
14	Szreter, S. (2003).	Literature review	Not applicable	To delineate the evolution of a population health approach to care delivery from 1500-2100	The growth of the economy resulted in population health improvement only when the state or federal government intervened and reallocated a portion of the new wealth toward programs and services that directly influence determinants of health	5A

Strength of Evidence Legend

Level 1
Experimental Study (Randomized Controlled Trial or RCT)
Meta-analysis of RCTs

Level 2
Quasi-experimental Study

Level 3
Non-experimental Study
Qualitative Study
Meta-synthesis

Level 4
Systematic Review
Clinical Practice Guidelines

Level 5
Organizational
Expert Opinion, Case Study, Literature Review

Quality of Rating Legend

A – High Quality
B – Good Quality
C – Low Quality or Major Flaws

Source: Newhouse, R., Dearholt, S., Poe, S., Pugh, L., White, K. (2007). *Johns Hopkins Nursing Evidence-Based Practice Model and Guidelines.* Sigma Theta Tau International

Appendix M

Definition of Terms

Term	Definition
Community Benefit	"Programs and services designed to improve health in communities and increase access to health care. They are integral to the mission of Catholic and other not-for-profit health care organizations, and are the basis of tax exemption. Community benefits calculation typically includes the cost of providing: Financial assistance programs, unfunded services for Medicaid and Medicare programs, health professional education and training, research, cash donations, in-kind contributions, community building activities, and the administration of community benefit programs" (Catholic Health Association, 2014).
Community Health Needs Assessment	"A process that uses quantitative and qualitative methods to systematically collect and analyze data to understand health within a specific community. An ideal assessment includes information on risk factors, quality of life, mortality, morbidity, community assets, forces of change, social determinants of health and health inequity, and information on how well the public health system provides essential services. Community health assessment data inform community decision-making, the prioritization of health problems, and the development, implementation, and evaluation of community health improvement plans" (NACCP, 2014).
Community Health Status Indicators	Community Health Status Indicators (CHSI) are nationally available health indicators for monitoring and analyzing community health status and its determinants at the county level. The purpose of CHSIs is to support the mission and goals of public health, the 10 Essential Public Health Services, Healthy People 2010 initiatives, and evidence-based policy and research (US National Library of Medicine – NIH).
Community Investment	A term used internally by Providence to describe processes that are focused on the administration and funding of community benefit related programs and services. This includes but is not limited to: Payments for free or subsidized care; community health needs assessment and intervention; and compliance with communication and reporting (Source not documented).
Community Investment Framework	The structure, resources and processes established by Providence to execute community benefit activities. This includes but is not limited to: Formal and informal councils and other team structures; dedicated and shared staff; budgets; communication, analytic and reporting tools; and policies and procedures (Source not documented).

Term	Definition
Governance Structure	"The way that a city, company, etc., is controlled by the people who run it" (Merriam-Webster, 2014).
Health	"Absence of disease; wellness and well-being" (Kindig, 2007, p. 142).
Implementation Plan	"A long-term, systematic effort to address public health problems on the basis of the results of community health assessment activities and the community health improvement process. This plan is used by health and other governmental education and human service agencies, in collaboration with community partners, to set priorities and coordinate and target resource" (NACCP, 2014).
Longitudinal	"Involving the repeated observation or examination of a set of subjects over time with respect to one or more study variables" (Merriman-Webster, 2014).
Patient Protection and Affordable Care Act	Legislation enacted in 2010 that "…put in place comprehensive health insurance reforms. The law makes preventive care—including family planning and related care—more accessible and affordable for many Americans" (US Department of Health & Human Services, 2014). A section of the law mandated the conduction of a Community Health Needs Assessment and Implementation Plan every three years as a requirement for a non-profit, tax-free hospital status (IRS, 2011).
Population	"A group of individuals, in contrast to the individuals themselves, organized into many different units of analysis, depending on the research or policy purpose. Whereas many interventions …focus exclusively on individuals, population health policy and research concentrate on the aggregate health of population groups like those in geographic units … or other characteristics" (Kindig, 2007, p. 142).
Population Health	"The health outcomes of a group of individuals, including the distribution of such outcomes within the group" (Kindig and Stoddart, 2003). "A population health perspective is fundamentally concerned with the social structural nature of health influences, and, although it is embodied in the health outcomes experienced by specific individuals, the domains of influence that shape experiences transcend the characteristics of circumstances of any one individual" (Dunn and Hayes, 1999, p. S7).

Term	Definition
Population Health Approach	The design and delivery of care organized by population health principles or framework (Kindig, 2007).
Population Health Framework	"Conceptual framework for thinking about why some populations are healthier than others and the policy development, research agenda, and resource allocation that flow from this. The difference between it and terms such as community health and public health; which have been around a long time is subtle" (Young, 2004, p. 4).
Population Health Model	A care delivery model that gives "significant attention to the multiple determinants of …health outcomes, however measured. These determinants include medical care, public health interventions, aspects of the social environment… the physical environment …, genetics, and individual behavior. ..population health research is fundamentally concerned about the interactions between (the determinants)…A population health perspective also requires attention to the resource allocation…The study of population health involves the estimation of the cross-sectoral cost-effectiveness of different types and combinations of investments for producing health…Requires the attention and actions of multiple actors (legislators, managers, providers, and individuals)…Needs to pay careful attention to the knowledge transfer and academic-practice partnerships" (Kindig and Stoddart, 2003).
Public Health	"Public health promotes and protects the health of people and the communities where they live, learn, work and play. From conducting scientific research to educating about health, people in the field of public health work to assure the conditions in which people can be healthy…Public health works to track disease outbreaks, prevent injuries and shed light on why some are more likely to suffer from poor health than others" (American Public Health Association, 2014). "Public health refers to all organized measures (whether public or private) to prevent disease, promote health, and prolong life among the population as a whole. Its activities aim to provide conditions in which people can be healthy and focus on entire populations, not on individual patients or diseases. Thus, public health is concerned with the total system and not only the eradication of a particular disease" (World Health Organization, 2014).
SharePoint site	A web application program developed by Microsoft that allows for collaboration, business intelligence, enterprise content management, and people and personalization services (Microsoft, 2014).

Term	Definition
Standardization	As interpreted by Providence, standardization is a defined process for the execution of tasks or activities (Source not documented).

Appendix N

DNP Project Approval Form: Statement of Determination

Student Name: Sandra Gregg

Title of Project: The Transformation of Systems and Structures to Advance a Population Health Approach for Care Delivery

Brief Description of Project:

A) Aim Statement:

Providence Health & Services acknowledges that traditional approaches to quality improvement and health care delivery are no longer effective in achieving community health and wellness goals. In order to optimize community benefit investments Providence seeks to transform its systems and structures designed to improve the health of the communities in which it offers programs and services. To achieve this goal, Providence will establish a governance process, determine organization-wide priorities for advancing a population health approach, standardize existing tools, and establish common success measures by June 2015.

B) Description of Intervention:

The intervention will be conducted in four phases.

Phase I: Project Planning and Approval

- Key deliverables
  - Definition of project
  - Approval of project by Providence Health & Services and USF School of Nursing
  - Development of project work plan and timeline
  - Establishment of Project Committee
- Timeline
  - Summer and Fall 2014

Phase II: Establishment of Governance

- Key deliverables
  - Establishment of Community Investment and Development Governance Council
  - Selection and orientation of Council members
  - Establishment of work groups to design and implement initiatives

Timeline
- Late Summer 2014

Phase III: Development of Recommendations for Prioritized Initiatives, Standard Tools and Processes, and Common Success Measures
- Key deliverables
  - Strategic priorities for advancing a population health approach
  - A list of tools or process to be standardized across the organization, along with a plan for completing to work
  - Measures of Success
- Timeframe
  - Fall 2014 – Winter 2015

Phase IV: Approval, Communication, and Implementation of Proposed Recommendations
- Key deliverables
  - Vet recommendations with key internal and external stakeholders
  - Secure approval of recommendations by Senior Vice President, Community Partnerships and Boards of Directors as appropriate
  - Communicate approved initiatives to management via leadership meetings and newsletters
  - Establish implementation teams to execute initiatives
  - Develop dashboard to track and report status of initiatives
- Timeline
  - Spring – Summer 2015

C) How will this intervention change practice?

This intervention will influence practice and process for addressing community health needs in the following manner:

- The Governance Council and related work groups structures offers a new mechanism for inter- and intra-professional discussion and prioritization of community health improvement initiatives;

- The standardization of tools, processes, and tracking and reporting of success measures provides the opportunity to benchmark internally and spread evidence-based best practices across the organization; and,

- The organization-wide collaboration on strategic initiatives allows for the optimization of community investment through the elimination of redundant processes, the leveraging of human and financial resources, and the reallocation of funds into additional programs and services.

D) Outcome measurements:

The success measures for this project include both outcome and process measures:

Outcome measure

- 100% of acute care hospitals are compliant with IRS guidelines for Community Health Needs Assessments for all surveys completed on or after 2012 by December 31, 2014

Process measures

- Community Investment Governance Council established and meeting routinely by December 31, 2014

- Organization-wide priorities to advance a population health approach are identified by December 31, 2014

- Standardized tools and processes are developed by June 30, 2015

- Metrics for measuring community health status developed, tracked and reported by June 30, 2015

To qualify as an Evidence-based Change in Practice Project, rather than a Research Project, the criteria outlined in federal guidelines will be used: (http://answers.hhs.gov/ohrp/categories/1569)

X This project meets the guidelines for an Evidence-based Change in Practice Project as outlined in the Project Checklist (attached). Student may proceed with implementation.

☐ This project involves research with human subjects and must be submitted for IRB approval before project activity can commence.

Comments:

EVIDENCE-BASED CHANGE OF PRACTICE PROJECT CHECKLIST *

Instructions: Answer YES or NO to each of the following statements:

Project Title:	**YES**	**NO**
The aim of the project is to improve the process or delivery of care with established/ accepted standards, or to implement evidence-based change. There is no intention of using the data for research purposes.	**X**	
The specific aim is to improve performance on a specific service or program and **is a part of usual care**. ALL participants will receive standard of care.	**X**	
The project is **NOT** designed to follow a research design, e.g., hypothesis testing or group comparison, randomization, control groups, prospective comparison groups, cross-sectional, case control). The project does **NOT** follow a protocol that overrides clinical decision-making.	**X**	
The project involves implementation of established and tested quality standards and/or systematic monitoring, assessment or evaluation of the organization to ensure that existing quality standards are being met. The project does **NOT** develop paradigms or untested methods or new untested standards.	**X**	
The project involves implementation of care practices and interventions that are consensus-based or evidence-based. The project does **NOT** seek to test an intervention that is beyond current science and experience.	**X**	
The project is conducted by staff where the project will take place and involves staff who are working at an agency that has an agreement with USF SONHP.	**X**	
The project has **NO** funding from federal agencies or research-focused organizations and is not receiving funding for implementation research.	**X**	
The agency or clinical practice unit agrees that this is a project that will be implemented to improve the process or delivery of care, i.e., **not** a personal research project that is dependent upon the voluntary participation of colleagues, students and/ or patients.	**X**	
If there is an intent to, or possibility of publishing your work, you and supervising faculty and the agency oversight committee are comfortable with the following statement in your methods section: *"This project was undertaken as an Evidence-based change of practice project at X hospital or agency and as such was not formally supervised by the Institutional Review Board."*	**X**	

ANSWER KEY: If the answer to **ALL** of these items is yes, the project can be considered an Evidence-based activity that does NOT meet the definition of research. **IRB review is not required. Keep a copy of this checklist in your files.** If the answer to ANY of these questions is **NO**, you must submit for IRB approval.

*Adapted with permission of Elizabeth L. Hohmann, MD, Director and Chair, Partners Human Research Committee, Partners Health System, Boston, MA.

STUDENT NAME (Please print): Sandra Gregg

Signature of Student:
Sandra Gregg **DATE 8/13/2014**

SUPERVISING FACULTY MEMBER (CHAIR) NAME (Please print):

Signature of Supervising Faculty Member (Chair) **DATE** 8/13/1

Appendix O

Letter of Organizational Support

PROVIDENCE
Health & Services

October 6, 2014

School of Nursing and Health Professions
University of San Francisco
2130 Fulton Street
San Francisco, California 94117-1080

Dear Executive Leadership Doctoral of Nursing Practice Faculty,

On behalf of Providence Health & Services I am submitting this letter of support for the project Sandra Gregg has selected as a requirement of her doctoral program. Sandy has been, and will continue to develop and / or support initiatives to establish effective systems and structures to advance community health improvement. Sandy and I discuss the progress of this work on a routine basis, approximately three to four times per month. I am confident that we will successfully achieve several key milestones by spring 2015.

Respectfully yours,

Joel Gilbertson
Sr. Vice President, Community Partnerships
Providence Health & Services